

933

CERTIFICATE OF DEATH

Reg. Dist. No. 342

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. LENGTH OF STAY IN IB 41 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle R. Last Adams		4. DATE OF DEATH Month 1-10- Day 19 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29 1909
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 10 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edwin Adams		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Vero O. Adams		Address wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction (old and recent) 420.1 DUE TO Thrombosis of left coronary artery, old (b) Thrombosis of right coronary artery, recent DUE TO Coronary Arteriosclerotic Heart Disease (c) ?		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 1 year 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-31 , 19 56 , to 1-10 , 19 57 , that I last saw the deceased alive on 1-10 , 19 57 , and that death occurred at 11:25 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Wt. Rainier and DATE SIGNED 1-10-57			
ACTUAL SIGNATURE Waldo B. Moyers M.D. Wt. Rainier and			
PHYSICIAN'S NAME (Type) Waldo B. Moyers			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/57	
22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) (State) Faces Church, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee & Sons Co.		ADDRESS 300 4th St. N.E.	
24a. REC'D BY REGISTRAR DATE 1-14-57		24b. REGISTRAR'S SIGNATURE Carne Campbell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

603

NAME OF DECEASED JAMES M. HARRIS		AGE 65		SEX Male		RACE White		DATE OF BIRTH Jan. 15, 1874		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Retired		EDUCATION High School		MARRIAGE Married		RELIGION Roman Catholic		DATE OF DEATH Jan. 17, 1939		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PERIOD OF ILLNESS Several days		PREVIOUS ILLNESS None		DATE OF INTERVIEW Jan. 17, 1939		INTERVIEWER J. M. Harris	

SIGNATURE OF DECEASED James M. Harris		SIGNATURE OF WITNESS J. M. Harris		SIGNATURE OF PHYSICIAN J. M. Harris		SIGNATURE OF CLERK J. M. Harris		SIGNATURE OF REGISTRAR J. M. Harris		SIGNATURE OF DEPUTY REGISTRAR J. M. Harris	
DATE OF SIGNATURE Jan. 17, 1939		DATE OF SIGNATURE Jan. 17, 1939		DATE OF SIGNATURE Jan. 17, 1939		DATE OF SIGNATURE Jan. 17, 1939		DATE OF SIGNATURE Jan. 17, 1939		DATE OF SIGNATURE Jan. 17, 1939	

BUREAU V. S.

JAN 17 1939

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

934

CERTIFICATE OF DEATH

02065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Allen				4. DATE OF DEATH Month Jan Day 12 Year 19 57			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 Jan 57	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY —			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Francis L Allen				14. MOTHER'S MAIDEN NAME Annie Evelyn Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT mother - as above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intercranial Hemorrhage DUE TO 760.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tear of Tentorium Cerebelli DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan 11, 1957 to Jan 12, 1957 , that I last saw the deceased alive on Jan 12, 1957 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Perkins				ADDRESS (Street, city or town, state) 5301 Hamilton St. Hyattsville			
PHYSICIAN'S NAME (Type) John W. Perkins				DATE SIGNED 1/12/57			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Feb 1957		Prince Georges Land		Cheverly Md	
23. FUNERAL DIRECTOR'S SIGNATURE Alvin W. Perkins				ADDRESS Adm		24a. REC'D BY REGISTRAR Feb 13 57	
24b. REGISTRAR'S SIGNATURE W. H. Houch				DATE			

207743 19XV7

CERTIFICATE OF DEATH

331

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

02807

Reg. No. 4-1

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]	
6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]		10. SIGNATURE OF DECEASED [Faint text]	
11. SIGNATURE OF WITNESS [Faint text]		12. SIGNATURE OF PHYSICIAN [Faint text]		13. SIGNATURE OF CLERK [Faint text]		14. SIGNATURE OF REGISTRAR [Faint text]		15. SIGNATURE OF JUDGE [Faint text]	
16. SIGNATURE OF SHERIFF [Faint text]		17. SIGNATURE OF CORONER [Faint text]		18. SIGNATURE OF JURY [Faint text]		19. SIGNATURE OF COURT [Faint text]		20. SIGNATURE OF STATE [Faint text]	

BUREAU V. 2

FEB 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00921

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pri. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS /			
3. NAME OF DECEASED (Type or print) Basil Robert Howard Anderson				4. DATE OF DEATH Month Jan. Day 3rd Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1977		9. AGE (In years last birthday) 79 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Randolph Anderson				14. MOTHER'S MAIDEN NAME Cecelia Hopkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Laura Browning. Laurel, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO (b) Lobar pneumonia (c) Fractured ribs and intracranial hemorrhage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in his own home					
20c. TIME OF INJURY Month, Day, Year Hour xx m. 12-30-56 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
20f. (City or town) Bowie		(County) Pr. Geo.		(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED January 3, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cemetery			
22d. LOCATION (City, town, or county) Collington, Maryland		22e. (State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE William H. Sanderson				24a. REC'D BY REGISTRAR JAN 9 57			
ADDRESS Laurel, Maryland				24b. REGISTRAR'S SIGNATURE W. H. Sanderson			

TO THE DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 9 1957

BUREAU V. 3

Indicated wife and interventional partnership

Call in his own home

xx 12-30-56

Home x

Other pneumonia

Toronto

Large pneumonia, small, pneumonia

Small pneumonia

Michigan

U.S.A.

Feb 2, 1957

Anderson

Howard

Robert

George General Hospital

Bone

2000

Overly

England

George

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1001

CERTIFICATE OF DEATH

0092273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 2 Beltsville, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5224 Cochran Road		d. STREET ADDRESS 5224 Cochran Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bertha Viola Ashley		4. DATE OF DEATH Month Day Year JAN 12 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1898
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John H. Riley		14. MOTHER'S MAIDEN NAME Kathryn Stumph	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT Upton S. Ashley		Address Beltsville, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor (Glio-Blastoma) 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) multiforme Meningeal (c) 3 mos		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1956 to Jan 1957, that I last saw the deceased alive on Jan 1957, and that death occurred at 9 PM, from the causes and on the date stated above. ACTUAL SIGNATURE W. C. Etienne M.D. 4713 - Berwyn Dr 1-12-57 DATE SIGNED PHYSICIAN'S NAME (Type) W. C. Etienne College Park, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/57	
22c. NAME OF CEMETERY OR CREMATORY Port Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE 16 1957		24b. REGISTRAR'S SIGNATURE John A. Smith	

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

936 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00923

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Lanham			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Route 2, Box 145, 3rd St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle Caemmerer Last Barber				4. DATE OF DEATH Month January Day 2 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1885		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Frederick Caemmerer				14. MOTHER'S MAIDEN NAME Johanna Kott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Patricia Kragh		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 442 X IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED January 2, 1956	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) Suitland, Md.		22e. NAME OF CEMETERY OR CREMATORY Suitland, Md.		22f. LOCATION (City, town, or county) Suitland, Md.		22g. LOCATION (City, town, or county) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR 7 57		24b. REGISTRAR'S SIGNATURE W. H. ...	

MEDICAL CERTIFICATION

TO THE JURY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U.S. MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to blurriness and bleed-through from the reverse side.

BUREAU V. S.

JAN 2 1957

RECEIVED

929

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince george MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 3133 Queens Chapel Rd.			
3. NAME OF DECEASED (Type or print) Juliette Hungerford Barber				4. DATE OF DEATH Month 1 Day 11 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1867		9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Gerard W. Hungerford				14. MOTHER'S MAIDEN NAME Nannie Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Winifred Grant Address Washington DC.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart failure DUE TO (b) Hypertension and arteriosclerosis DUE TO (c) Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1-10-1957 to 1-11-1957 , that I last saw the deceased alive on 1-10-1957 , and that death occurred at 1:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jules Gilbert				ADDRESS (Street, city or town, state) 3200 Ashmun Rd. Mt. Rainier Md			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Jules Gilbert, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Jan 14, 1957		Windsor Cemetery		Windsor Md	
23. FUNERAL DIRECTOR'S SIGNATURE The Spuntt Funeral Home, Baltimore, Md				24a. REC'D BY REGISTRAR JAN 16 1957		24b. REGISTRAR'S SIGNATURE James E. Seaver	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 16 1957

BUREAU A. S.

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18		CERTIFICATE OF DEATH	
Name of Deceased George Washington		Date of Death January 15, 1957	
Age 78 years		Sex Male	
Race White		Marital Status Married	
Place of Birth Baltimore, Maryland		Usual Residence Baltimore, Maryland	
Cause of Death Heart Disease		Immediate Cause of Death Myocardial Infarction	
Contributing Cause of Death Hypertension		Manner of Death Natural	
Physician's Signature [Signature]		Medical Examiner's Signature [Signature]	
Date of Death January 15, 1957		Time of Death 10:30 AM	
Place of Death Home		Hospital or Institution None	
Signature of Informant [Signature]		Relationship to Deceased Wife	
Signature of Physician [Signature]		Signature of Medical Examiner [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00925

Reg. Dist. No.

<p>1. PLACE OF DEATH o. COUNTY <u>Prince Georges County</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md.</u></p>				<p>c. LENGTH OF STAY IN 1b <u>21 days</u></p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u></p>				<p>e. STREET ADDRESS <u>3rd & Telegraph Road</u></p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First <u>Williams</u> Middle <u>Gover</u> Last <u>Barber</u></p>				<p>4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1957</u></p>			
<p>5. SEX <u>Male</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>June 27-1885</u></p>	
<p>9. AGE (In years last birthday) <u>72</u> yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u></p>	
<p>11. BIRTHPLACE (State or foreign country) <u>Md</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u></p>			
<p>13. FATHER'S NAME <u>George A. Barber</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Isabella Collinson</u></p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO. <u>579 26 724</u></p>			
<p>17. INFORMANT <u>Patricia B - Kragh - Forest Hts, Ind</u> Address</p>							
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular - Decident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis.</u> DUE TO (c)</p>							<p>INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>	
<p>20f. (City or town) (County) (State)</p>							
<p>21. I certify that I attended the deceased from <u>Jan. 2</u>, 19<u>57</u>, to <u>Jan. 23</u>, 19<u>57</u>, that I last saw the deceased alive on <u>Jan. 23</u>, 19<u>57</u>, and that death occurred at <u>7/45</u> M, from the causes and on the date stated above.</p>							
<p>ACTUAL SIGNATURE <u>Hans Wodak</u></p>				<p>ADDRESS (Street, city or town, state) <u>30-C RINGE RD, GREENBELT, MD 20745</u></p>			
<p>DATE SIGNED <u>Jan 28 '57</u></p>							
<p>PHYSICIAN'S NAME (Type) <u>HANS WODAK</u></p>							
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>22b. DATE THEREOF <u>1/26 1957</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>Edgar Hill</u></p>		<p>22d. LOCATION (City, town, or county) (State) <u>Smithland Md</u></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch sons Hyattsville, Md</u> ADDRESS</p>				<p>24a. REC'D BY REGISTRAR <u>Jan 28 '57</u></p>		<p>24b. REGISTRAR'S SIGNATURE <u>Reber</u></p>	

MEDICAL CERTIFICATION

TO HOWARD AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		RACE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	

BUREAU V. S.

IAN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

938

CERTIFICATE OF DEATH

00926

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>	c. LENGTH OF STAY IN 1b <i>8 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xotainmont Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Prince Georges Gen. Hosp.</i>		d. STREET ADDRESS <i>803 Addison Rd.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Alice</i> First <i>Baton</i> Middle Last		4. DATE OF DEATH Month <i>January</i> Day <i>2</i> Year <i>1957</i>	
5. SEX <i>7</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-4-96</i>
9. AGE (In years last birthday) <i>60</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Govt Worker</i>	11. BIRTHPLACE (State foreign country) <i>Wash DC</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John H. Srawley</i>	
14. MOTHER'S MAIDEN NAME <i>Elyse Guilmon</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>270</i>		17. INFORMANT <i>Harry Baton</i> Address <i>803 Addison Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro Vascular accident</i> DUE TO <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Essential hypertension</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>Unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>12-26</i> , 19 <i>56</i> , to <i>1-2</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1-1</i> , 19 <i>57</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>John H. Srawley</i> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>1-5-57</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Frederick Md.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nancy Washington</i>		ADDRESS <i>467 N St NW</i>	
24a. REC'D BY REGISTRAR DATE <i>JAN 8 '57</i>		24b. REGISTRAR'S SIGNATURE <i>Overman</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. RACE		9. COLOR		10. RELIGION	
11. DATE OF DEATH		12. TIME OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	

BUREAU V. S.

JAN 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00927

939

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Chesley Rindale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen</u>		d. STREET ADDRESS <u>1 5602 Longfellow St</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Bay Beall</u>		4. DATE OF DEATH <u>Jan 13 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12, 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul F. Beall</u>		14. MOTHER'S MAIDEN NAME <u>Jo Ann Lock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Paul F. Beall (Father)</u>		Address <u>Same add. as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0</u> DUE TO <u>Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital non-expansion of lungs</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/12/57</u> 19 <u>57</u> to <u>1/13</u> 19 <u>57</u> that I last saw the deceased alive on <u>1/13</u> 19 <u>57</u> and that death occurred at <u></u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Rubins</u>		ADDRESS (Street, city or town, state) <u>5301 Hamilton St, Hyatts.</u> DATE SIGNED <u>1/13/57</u>	
PHYSICIAN'S NAME (Type) <u>John W.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 15, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland</u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u></u>	
DATE <u>JAN 17 '57</u>			

2077201XV3

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		MARRIAGE [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	

BUREAU V. 5

JAN 17 1957

RECEIVED

940
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mamie Middle ELLEN Last Bicksler		4. DATE OF DEATH Month Jan Day 8 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-17-1882
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 4 Hours 15 Min.	11. IF UNDER 24 HRS. Months 7 Days 4 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) LEESBURG, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALVARADO HARBY		14. MOTHER'S MAIDEN NAME HATTIE ATWELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS MARGARET STINE		Address MARYLAND PK, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 331X DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6 years DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 7, 1957 , to Jan 8, 1957 , that I last saw the deceased alive on Jan 7, 1957 and that death occurred at 6:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stuart Woodruff		DATE SIGNED 30 C Bridge Rd, Greenbelt, Md.	
PHYSICIAN'S NAME (Type)		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-11-57	22c. NAME OF CEMETERY OR CREMATORY CHESTNUT GROVE	22d. LOCATION (City, town, or county) (State) HERNDON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., Washington, D.C.		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE Quelch

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1957 11 Nov

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00929

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi		c. LENGTH OF STAY IN lb 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1928 Merrimack Drive Ave. - Drive				d. STREET ADDRESS 1928 Merrimack Drive Ave.			
3. NAME OF DECEASED (Type or Print) Phillip Thomas Boundford				4. DATE OF DEATH Month January Day 5 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Nov. 19, 1916		9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 40 Days 5 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Govt Printing Office		11. BIRTHPLACE (State or foreign country) Dis. of Col.			
13. FATHER'S NAME Louis Boundford				14. MOTHER'S MAIDEN NAME Margaret Madden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.2		17. INFORMANT Margaret Boundford; same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PR. I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart failure 442 X DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. </div>							
PR. II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED January 5, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/8/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			
22d. LOCATION (City, town, or county) Suitland, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.				24a. REC'D BY REGISTRAR JAN 9 1957			
24b. REGISTRAR'S SIGNATURE <i>H. W. Hedrick</i>				DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please advise the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 9 1957

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
1. Name of Deceased: Thomas, William	
2. Date of Death: Nov. 19, 1956	
3. Place of Death: Home, 1234 Main St., Chicago, Ill.	
4. Cause of Death: Heart failure	
5. Manner of Death: Natural	
6. Signature of Medical Examiner: [Signature]	
7. Date of Examination: Nov. 20, 1956	
8. Location of Examination: Home	
9. Name of Physician: [Signature]	
10. Date of Referral: Nov. 18, 1956	
11. Name of Referring Physician: [Signature]	
12. Name of Hospital: [Blank]	
13. Name of Doctor: [Blank]	
14. Name of Nurse: [Blank]	
15. Name of Embalmer: [Blank]	
16. Name of Undertaker: [Blank]	
17. Name of Funeral Home: [Blank]	
18. Name of Cemetery: [Blank]	
19. Name of Burial Place: [Blank]	
20. Name of Interment: [Blank]	
21. Name of Final Disposition: [Blank]	
22. Name of Final Disposition: [Blank]	
23. Name of Final Disposition: [Blank]	
24. Name of Final Disposition: [Blank]	
25. Name of Final Disposition: [Blank]	
26. Name of Final Disposition: [Blank]	
27. Name of Final Disposition: [Blank]	
28. Name of Final Disposition: [Blank]	
29. Name of Final Disposition: [Blank]	
30. Name of Final Disposition: [Blank]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

941 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00930

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 3817 40th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOE Middle L. Last BROOKE				4. DATE OF DEATH Jan Month 30 Day 19 Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 Feb 1890	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S.P.O.		11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard J. Brooke				14. MOTHER'S MAIDEN NAME Alice R. Albright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None		17. INFORMANT Mamie M. Brooke Same as # 2 (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED 30 Jan 1957			
EXAMINER'S NAME (Type) JOHN T. MALONEY, M. D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Ceme.		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE FEB 1 57		24b. REGISTRAR'S SIGNATURE Arlington	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2-21 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 1 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00931

Reg. Dist. No.

1003

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodyard</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodyard</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Woodyard Road</u>				d. STREET ADDRESS <u>Woodyard Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Augustine</u> Middle <u>Brown</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		10. UNDER 1 YEAR Months <u>21</u> Days <u>21</u> Hours <u>19</u> Min. <u>57</u>		11. AGE (In years last birthday) <u>56</u> yrs.		12. UNDER 24 HRS. Months <u>21</u> Days <u>21</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Patrick Brown</u>				14. MOTHER'S MAIDEN NAME <u>Mary M. Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Mable Brown, phone #2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra cranial hemorrhage</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-25-57</u>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <u>Marquise Catholic Church</u>				22d. LOCATION (City, town, or county) (State) <u>Kosadesville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle L. Rollins</u>				24a. REC'D BY REGISTRAR <u>25 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>H. H. Sedwick</u>				24c. DATE			

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JAN 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00932

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1004

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x-3 Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1345 - 14th St., N.W.	
3. NAME OF DECEASED (Type or print) First Carroll Middle Brown Last Brown		4. DATE OF DEATH Month Jan. Day 30 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/27/06
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Brown		14. MOTHER'S MAIDEN NAME Elizabeth Hutchins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-09-6227	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma, left lung 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 19, 19 56 , to Jan. 30, 19 57 , that I last saw the deceased alive on January 30, 19 57 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Daniel Leo Finucane, M.D. Glenn Dale Hospital, Glenn Dale, Md. 1/30/57			
ACTUAL SIGNATURE Daniel Leo Finucane			
PHYSICIAN'S NAME (Type) Daniel Leo Finucane			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/31/57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE John D. Watson 1700 Vt. ave District of Columbia Funeral Home		24a. REC'D BY REGISTRAR 1/30/57 24b. REGISTRAR'S SIGNATURE W. H. Wess	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF REGISTRAR		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF WITNESSES	
JAMES EARL RAY		Male		35		May 19, 1928		Memphis, Tennessee		Attorney at Law		Shot in the back		Suicide		[Signature]		[Signature]		[Signature]	
12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. SEX OF DECEASED		16. AGE OF DECEASED		17. DATE OF BIRTH		18. PLACE OF BIRTH		19. OCCUPATION		20. CAUSE OF DEATH		21. MANNER OF DEATH		22. SIGNATURE OF REGISTRAR	
Baltimore, Maryland		May 23, 1968		10:00 AM		Male		35		May 19, 1928		Memphis, Tennessee		Attorney at Law		Shot in the back		Suicide		[Signature]	
23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF WITNESSES		25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF PHYSICIAN		27. SIGNATURE OF WITNESSES		28. SIGNATURE OF REGISTRAR		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF WITNESSES		31. SIGNATURE OF REGISTRAR		32. SIGNATURE OF PHYSICIAN		33. SIGNATURE OF WITNESSES	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

FEB 5 1967

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

942

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS Box 23	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle L Last Brown		4. DATE OF DEATH Month Jan Day 27 Year 19 57	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 70 yrs.
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1-31-51	
17. INFORMANT Bladenburg		Address Bladenburg	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 590x DUE TO Acute renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute renal failure DUE TO Acute renal failure (c) Acute renal failure			INTERVAL BETWEEN ONSET AND DEATH 1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:30A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John T. Khunz M.D.		ADDRESS (Street, city or town, state) Bladenburg Md	
DATE SIGNED Feb 1 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-31-51	
22c. NAME OF CEMETERY OR CREMATORY Church		22d. LOCATION (City, town, or county) (State) ROSARY VILLE M.D.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Khunz		ADDRESS No. 901-3rd St. S.W.	
24a. REC'D BY REGISTRAR Feb 1 57		24b. REGISTRAR'S SIGNATURE Bladenburg	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. DATE			
JAMES H. HARRIS		Male		45		White		1912		Maryland		1957		Baltimore		Heart Disease		Natural		J. H. Harris		Feb 1 1957			
13. FULL NAME OF PHYSICIAN		14. FULL NAME OF SURGEON		15. FULL NAME OF PATHOLOGIST		16. FULL NAME OF FORENSIC EXAMINER		17. FULL NAME OF MENTAL EXAMINER		18. FULL NAME OF NURSE		19. FULL NAME OF CHAPLAIN		20. FULL NAME OF MINISTER		21. FULL NAME OF OTHER		22. FULL NAME OF OTHER		23. FULL NAME OF OTHER		24. FULL NAME OF OTHER		25. FULL NAME OF OTHER	
Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris	
13. FULL NAME OF PHYSICIAN		14. FULL NAME OF SURGEON		15. FULL NAME OF PATHOLOGIST		16. FULL NAME OF FORENSIC EXAMINER		17. FULL NAME OF MENTAL EXAMINER		18. FULL NAME OF NURSE		19. FULL NAME OF CHAPLAIN		20. FULL NAME OF MINISTER		21. FULL NAME OF OTHER		22. FULL NAME OF OTHER		23. FULL NAME OF OTHER		24. FULL NAME OF OTHER		25. FULL NAME OF OTHER	
Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris		Dr. J. H. Harris	

RECEIVED
 FEB 1 1957
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1005

CERTIFICATE OF DEATH

00934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Lanham</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Victoria</u> First <u>Brown</u> Middle <u>Brown</u> Last		4. DATE OF DEATH <u>1-19-57</u> Month <u>1</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Neuro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>90</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>WALTER CAMPBELL</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HERBERT BROWN</u> Address <u>LOTTSFORD RD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>450.1</u> DUE TO <u>Congestive at left & lower extremity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen. Arteriosclerosis</u> DUE TO (c) <u>Gen. Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 15, 1957</u> , to <u>Jan 19, 1957</u> , that I last saw the deceased alive on <u>Jan 12, 1957</u> , and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. H. G. Wise Jr</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 Volta St Lanham, md</u>	
DATE SIGNED <u>1/19/57</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 23, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Family Catholic</u>	22d. LOCATION (City, town, or county) (State) <u>Woodmore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Stewart</u> ADDRESS <u>30 H Street, N.E.</u>		24a. REC'D BY REGISTRAR <u>JAN 23 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Barrie Campbell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1005

CERTIFICATE OF DEATH

Reg. Dist. No. 009353

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (RURAL)</u>				c. LENGTH OF STAY IN 1b <u>1 yr, 12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>113 Eye St., N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>M.</u> Last <u>Cabell</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>15</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 8, 1924</u>	
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>19</u> Min. <u>57</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Cabell</u>				14. MOTHER'S MAIDEN NAME <u>Emily Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(lost)</u>		17. INFORMANT <u>Decedent</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary tuberculosis</u> <u>648.3</u> DUE TO (c) <u>4 yrs., 9 mo.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intrauterine pregnancy, 24 weeks.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 4, 1956</u> , to <u>Jan. 15, 1957</u> , that I last saw the deceased alive on <u>Jan. 15, 1957</u> , and that death occurred at <u>2:33 p.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Daniel Leo Finucane</u> M.D.				ADDRESS (Street, city or town, state) <u>Glenn Dale Hospt., Glenn Dale, Md.</u>			
DATE SIGNED <u>1/15/57</u>							
PHYSICIAN'S NAME (Type) <u>Daniel Leo Finucane</u>							
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1. 20. 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Amherst Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lynchburg Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN T RHINES-SON</u>				ADDRESS <u>901.3015.57</u>		24a. REC'D BY REGISTRAR DATE <u>1/15/57</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 21 1957	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
OCCUPATION		PLACE OF BIRTH	
Retired		Maryland	
DATE OF BIRTH		PLACE OF DEATH	
JAN 10 1957		Baltimore, Md.	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
IMMEDIATE CAUSE		FURTHER INFORMATION	
Myocardial Infarction		None	
UNDERLYING CAUSE		DATE OF EXAMINATION	
Coronary Atherosclerosis		JAN 21 1957	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
JAN 21 1957		Baltimore, Md.	
NAME OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
JAMES H. HARRIS		[Signature]	
NAME OF CORONER		SIGNATURE OF CORONER	
JAMES H. HARRIS		[Signature]	
NAME OF REGISTRAR		SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		[Signature]	

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JAN 21 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

943

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital.			d. STREET ADDRESS Box 5804; Sheriff Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Sarah Middle Chase Last Chase			4. DATE OF DEATH Month January Day 3, Year 19 57		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 28-1920	9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Chase			14. MOTHER'S MAIDEN NAME Alice Puffin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT Charles Chase Address Huntsville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia. DUE TO 3rd degree burns of body Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Dress caught fire from stove in home.			
20c. TIME OF INJURY Month, Day, Year Hour noon a. m. 12-25-56 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Landover	(County) Pr. Geo. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John J. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER fk January 3, 1956		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-7-57	22c. NAME OF CEMETERY OR CREMATORY M + Olivet		22d. LOCATION (City, town, or county) Wash. DC (State) DC	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S Washington		ADDRESS 467 N St NW		24a. REC'D BY REGISTRAR DATE 1-8-57	24b. REGISTRAR'S SIGNATURE Paul Smith

MEDICAL CERTIFICATION

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JAN 8 1957

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Gen. Hospital				d. STREET ADDRESS 6705 Hamilton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Eva Last Clarke				4. DATE OF DEATH Month January Day 4 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24 1898	
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months 5 Days 15		IF UNDER 24 HRS. Hours 15 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Cyrus Benten Manahan				14. MOTHER'S MAIDEN NAME Martha Virginia Cline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 578 28 5550		17. INFORMANT Vera Irene Stowell Address 6705 Hamilton St Riverdale, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) interval of fracture							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-30 , 19 57 , to 1-4 , 19 57 , that I last saw the deceased alive on 1-4 , 19 57 , and that death occurred at 1:55A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE T. H. Bergerman M.D.				ADDRESS (Street, city or town, state) 4314 Jellison Rd Hyattsville DATE SIGNED Feb 1 1957			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/7/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland.				24a. REC'D BY REGISTRAR JAN 7 57		24b. REGISTRAR'S SIGNATURE W. H. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

273

BUREAU V. S.

JAN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1007

CERTIFICATE OF DEATH

Reg. Dist. No.

00938

243

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)				c. LENGTH OF STAY IN It 1 yr., 1 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 Washington			
d. STREET ADDRESS 5012 Lowell St., N.W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle E. Last Cockfield				4. DATE OF DEATH Month 1 Day 10 Year 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/18/03	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Julius Cockfield				14. MOTHER'S MAIDEN NAME Katie E. Burgess			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary tuberculosis DUE TO (c) 1 month 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/18/55 , 19 55 , to 7/10 , 19 57 , that I last saw the deceased alive on 1/9 , 19 57 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Daniel Leo Finucane				ADDRESS (Street, city or town, state) Glenn Dale, Maryland		DATE SIGNED 1/10/57	
PHYSICIAN'S NAME (Type) Daniel Leo Finucane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/11/57		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE FRAZIER FUNERAL HOME				ADDRESS 389 R.I. Ave		24a. REC'D BY REGISTRAR DATE 1/10/57	
				24b. REGISTRAR'S SIGNATURE Walt Wiers			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1957	
AGE		SEX	
65		M	
RACE		OCCUPATION	
W		RETIRED	
BIRTHPLACE		PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
EDUCATION		MANNER OF DEATH	
HIGH SCHOOL		NATURAL CAUSE	
MARITAL STATUS		CAUSE OF DEATH	
MARRIED		HEART DISEASE	
PREVIOUS ILLNESS		IMMEDIATE CAUSE	
NONE		CORONARY THROMBOSIS	
TREATMENT		POST-MORTEM EXAMINATION	
NONE		NO	
BURIAL		SIGNATURE OF REGISTRAR	
CATHOLIC		JAMES H. HARRIS	
CITY		DATE	
BALTIMORE		JAN 15 1957	

RECEIVED
JAN 15 1957
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00939

945

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b 8Hr. 1/2Hr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH Month Jan Day 16 Year 1957							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 7 1957	
9. AGE (In years last birthday) 3 Moys.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Cheverly Md.		12. CITIZEN OF WHAT COUNTRY? Pr. George	
13. FATHER'S NAME Carmel Coleman				14. MOTHER'S MAIDEN NAME Hiroko Inoue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Carmel Coleman		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Broncho-Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							INTERVAL BETWEEN ONSET AND DEATH 18 Hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/11 , 19 57 , to 1/16 , 19 57 , that I last saw the deceased alive on 1/16 , 19 57 , and that death occurred at 8:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Rainier, Md. DATE SIGNED Jan 16, 1957							
ACTUAL SIGNATURE C. C. Hageage				PHYSICIAN'S NAME (Type) C. C. Hageage Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/18/1957		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery Riggs Rd. Hyattsville, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home				24a. REC'D BY REGISTRAR Jan 21 57		24b. REGISTRAR'S SIGNATURE Qu. Law	

AN 21 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

946

CERTIFICATE OF DEATH

00940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md.</u>		c. LENGTH OF STAY IN IB <u>8 Hours</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville Md.</u>		d. STREET ADDRESS <u>7615 Normandy Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>A.</u> Middle <u>Coronel</u> Last		4. DATE OF DEATH Month <u>Jan.</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 19, 1954</u>
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>Robert A. Coronel</u>		14. MOTHER'S MAIDEN NAME <u>Nobuko Nakamoto</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MENINGITIS ACUTE (H-INFLUENZA)</u> <u>340.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/22</u> , 19 <u>57</u> , to <u>1/22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/22</u> , 19 <u>57</u> , and that death occurred at <u>2:45 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7016 GARRIG ST.</u> DATE SIGNED <u>Seal Pleasant, Md.</u> ACTUAL SIGNATURE <u>Max M. Herzberg</u> M.D. PHYSICIAN'S NAME (Type) <u>Dr. Herzberg</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u> ADDRESS <u>317 Pa. Ave., SE DC3</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 24 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>			

CERTIFICATE OF DEATH

Reg. 501.100

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF BIRTH [REDACTED]</p>		<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. MARITAL STATUS [REDACTED]</p>	
<p>7. OCCUPATION [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>		<p>9. MANNER OF DEATH [REDACTED]</p>	
<p>10. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>11. SIGNATURE OF DECEASED [REDACTED]</p>		<p>12. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>13. DATE OF DEATH [REDACTED]</p>		<p>14. PLACE OF DEATH [REDACTED]</p>		<p>15. TIME OF DEATH [REDACTED]</p>	
<p>16. SIGNATURE OF DECEASED [REDACTED]</p>		<p>17. SIGNATURE OF WITNESS [REDACTED]</p>		<p>18. SIGNATURE OF REGISTRAR [REDACTED]</p>	

RECEIVED
JAN 24 1957
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00941

Reg. Dist. No.

1008

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4000 Block Bunker Hill Road		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier d. STREET ADDRESS 4236- 34th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Marion Last Corso		4. DATE OF DEATH Month January Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 11, 1936
9. AGE (In years last birthday) 20 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Banking	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dominick John Corso		14. MOTHER'S MAIDEN NAME Opal M'Cloud	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT John D. Corso, Jr.		Address Same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO 824X Universal 4th Degree burns of body Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Asphyxia, carbon monoxide poisoning, inhalation of smoke. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Buried as a result of conflagration in automobile.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1-19- 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Cottage City, Pr. Geo. Md.		(State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE JAN 23 '57	
24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>		DATE SIGNED January 19, 1957	

MEDICAL CERTIFICATION

60

1

2

16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 28 1957

BUREAU W. S.

Burned as a result of conflagration in automobile.

Asphyxia, carbon monoxide poisoning, inhalation of smoke.

Universal for three years of life.

Shook

John H. Corso, Jr. (dead address)

Domestic John Corso

Upel Wilson

Working

Virginia

U.S.A.

White

November 11, 1940

Corso

London

Richard

John Corso III (dead)

1938-39 Street

Upel Wilson

Upel Wilson

Domestic John Corso

Upel Wilson

Upel Wilson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00942

1009

CERTIFICATE OF DEATH

Reg. Dist. No.

734

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4617 Lewis Ave</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANTONIO</u> Middle <u>COSSIMANO</u> Last <u>COSSIMANO</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 23, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRODUCE DEALER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRODUCE</u>	
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>VINCENT COSSIMANO</u>		14. MOTHER'S MAIDEN NAME <u>CAMELIA QUARLINA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>TERESA COSSIMANO</u>		Address <u>4617 LEWIS AVE SUITLAND, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart Failure - Arteriosclerotic Heart Disease -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease -</u> (c) <u>Old Coronary Thrombosis - (3) -</u>			INTERVAL BETWEEN ONSET AND DEATH <u>17 Yrs.</u> <u>17 Yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subtotal gastrectomy for Bleeding tumor. 1953. Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-3-</u> , 19 <u>53</u> , to <u>1-26-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-25-</u> , 19 <u>57</u> , and that death occurred at <u>6:10</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Calabro</u>		ADDRESS (Street, city or town, state) <u>3801 Suitland Rd. S.E.</u>	
PHYSICIAN'S NAME (Type) <u>John J. Calabro M.D.</u>		DATE SIGNED <u>Washington 20, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN-30-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co Washington</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
24b. REGISTRAR'S SIGNATURE <u>Carie Campbell</u>		24c. DATE <u>JAN 29 1957</u>	

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 12 See: Birth Cert.

2355

CERTIFICATE OF DEATH

03214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Curtis</u>		4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 15, 1957</u> — yrs. <u>45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Elmer Bernard Curtis</u>		14. MOTHER'S MAIDEN NAME <u>Marguertie Virginia Savoy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pretermaturity</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/15</u> , 19 <u>57</u> , to <u>1/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/15/57</u> , 19 <u>57</u> , and that death occurred at <u>2:44</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Perkins</u> M.D.		ADDRESS (Street, city or town, state) <u>5301 Hamilton St. Hyattsville, Md.</u>	
DATE SIGNED <u>1/15/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. John Perkins</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Feb 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Annapolis Cemetery, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William N. Perkins</u> ADDRESS <u>Adrian</u>		24a. RECD BY REGISTRAR DATE <u>MAR 12 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Perkins</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED MARRIAGE		2. SEX MALE	
3. DATE OF BIRTH 1900		4. PLACE OF BIRTH BALTIMORE, MARYLAND	
5. OCCUPATION LABORER		6. CAUSE OF DEATH HEART DISEASE	
7. DATE OF DEATH MAY 12 1957		8. PLACE OF DEATH HOME	
9. SIGNATURE OF DECEASED (If living)		10. SIGNATURE OF WITNESSES (If living)	
11. SIGNATURE OF DECEASED (If deceased)		12. SIGNATURE OF WITNESSES (If deceased)	
13. SIGNATURE OF DECEASED (If deceased)		14. SIGNATURE OF WITNESSES (If deceased)	
15. SIGNATURE OF DECEASED (If deceased)		16. SIGNATURE OF WITNESSES (If deceased)	
17. SIGNATURE OF DECEASED (If deceased)		18. SIGNATURE OF WITNESSES (If deceased)	
19. SIGNATURE OF DECEASED (If deceased)		20. SIGNATURE OF WITNESSES (If deceased)	
21. SIGNATURE OF DECEASED (If deceased)		22. SIGNATURE OF WITNESSES (If deceased)	
23. SIGNATURE OF DECEASED (If deceased)		24. SIGNATURE OF WITNESSES (If deceased)	
25. SIGNATURE OF DECEASED (If deceased)		26. SIGNATURE OF WITNESSES (If deceased)	
27. SIGNATURE OF DECEASED (If deceased)		28. SIGNATURE OF WITNESSES (If deceased)	
29. SIGNATURE OF DECEASED (If deceased)		30. SIGNATURE OF WITNESSES (If deceased)	
31. SIGNATURE OF DECEASED (If deceased)		32. SIGNATURE OF WITNESSES (If deceased)	
33. SIGNATURE OF DECEASED (If deceased)		34. SIGNATURE OF WITNESSES (If deceased)	
35. SIGNATURE OF DECEASED (If deceased)		36. SIGNATURE OF WITNESSES (If deceased)	
37. SIGNATURE OF DECEASED (If deceased)		38. SIGNATURE OF WITNESSES (If deceased)	
39. SIGNATURE OF DECEASED (If deceased)		40. SIGNATURE OF WITNESSES (If deceased)	
41. SIGNATURE OF DECEASED (If deceased)		42. SIGNATURE OF WITNESSES (If deceased)	
43. SIGNATURE OF DECEASED (If deceased)		44. SIGNATURE OF WITNESSES (If deceased)	
45. SIGNATURE OF DECEASED (If deceased)		46. SIGNATURE OF WITNESSES (If deceased)	
47. SIGNATURE OF DECEASED (If deceased)		48. SIGNATURE OF WITNESSES (If deceased)	
49. SIGNATURE OF DECEASED (If deceased)		50. SIGNATURE OF WITNESSES (If deceased)	
51. SIGNATURE OF DECEASED (If deceased)		52. SIGNATURE OF WITNESSES (If deceased)	
53. SIGNATURE OF DECEASED (If deceased)		54. SIGNATURE OF WITNESSES (If deceased)	
55. SIGNATURE OF DECEASED (If deceased)		56. SIGNATURE OF WITNESSES (If deceased)	
57. SIGNATURE OF DECEASED (If deceased)		58. SIGNATURE OF WITNESSES (If deceased)	
59. SIGNATURE OF DECEASED (If deceased)		60. SIGNATURE OF WITNESSES (If deceased)	
61. SIGNATURE OF DECEASED (If deceased)		62. SIGNATURE OF WITNESSES (If deceased)	
63. SIGNATURE OF DECEASED (If deceased)		64. SIGNATURE OF WITNESSES (If deceased)	
65. SIGNATURE OF DECEASED (If deceased)		66. SIGNATURE OF WITNESSES (If deceased)	
67. SIGNATURE OF DECEASED (If deceased)		68. SIGNATURE OF WITNESSES (If deceased)	
69. SIGNATURE OF DECEASED (If deceased)		70. SIGNATURE OF WITNESSES (If deceased)	
71. SIGNATURE OF DECEASED (If deceased)		72. SIGNATURE OF WITNESSES (If deceased)	
73. SIGNATURE OF DECEASED (If deceased)		74. SIGNATURE OF WITNESSES (If deceased)	
75. SIGNATURE OF DECEASED (If deceased)		76. SIGNATURE OF WITNESSES (If deceased)	
77. SIGNATURE OF DECEASED (If deceased)		78. SIGNATURE OF WITNESSES (If deceased)	
79. SIGNATURE OF DECEASED (If deceased)		80. SIGNATURE OF WITNESSES (If deceased)	
81. SIGNATURE OF DECEASED (If deceased)		82. SIGNATURE OF WITNESSES (If deceased)	
83. SIGNATURE OF DECEASED (If deceased)		84. SIGNATURE OF WITNESSES (If deceased)	
85. SIGNATURE OF DECEASED (If deceased)		86. SIGNATURE OF WITNESSES (If deceased)	
87. SIGNATURE OF DECEASED (If deceased)		88. SIGNATURE OF WITNESSES (If deceased)	
89. SIGNATURE OF DECEASED (If deceased)		90. SIGNATURE OF WITNESSES (If deceased)	
91. SIGNATURE OF DECEASED (If deceased)		92. SIGNATURE OF WITNESSES (If deceased)	
93. SIGNATURE OF DECEASED (If deceased)		94. SIGNATURE OF WITNESSES (If deceased)	
95. SIGNATURE OF DECEASED (If deceased)		96. SIGNATURE OF WITNESSES (If deceased)	
97. SIGNATURE OF DECEASED (If deceased)		98. SIGNATURE OF WITNESSES (If deceased)	
99. SIGNATURE OF DECEASED (If deceased)		100. SIGNATURE OF WITNESSES (If deceased)	

BUREAU V. A.

MAR 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

948

CERTIFICATE OF DEATH

00944

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle E Last Dakin		4. DATE OF DEATH Month Jan Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 June 1886
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70	11. IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min. 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Reading, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Outram Dakin		14. MOTHER'S MAIDEN NAME Margaret Markell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 10/31/17-7/1/24		16. SOCIAL SECURITY NO. #025-03-7799	
17. INFORMANT Eliza B. Dakin Address address above		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chute from New Car 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Wrecking DUE TO (c) Spine, & Anterior	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-4 , 19 50 , to 1-19 , 19 57 , that I last saw the deceased alive on 1-18 , 19 57 , and that death occurred at 1:15A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Peety		ADDRESS (Street, city or town, state) DATE SIGNED H. J. Heald 1-19-57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hope		22d. LOCATION (City, town, or county) (State) Forest Hill, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley Funeral Home		24. REC'D BY REGISTRAR DATE JAN 30 1957	
ADDRESS 3200 - Rd. in Mt. Hope		24b. REGISTRAR'S SIGNATURE Outram	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
MARRIAGE		OCCUPATION	
RESIDENCE		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
FEE PAID		REMARKS	

BUREAU V. S.

JAN 23 1957

RECEIVED

1010

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILL CREST HEIGHTS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILL CREST HEIGHTS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5207-29th AVE.</u>				d. STREET ADDRESS <u>5207-29th AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ESSIE MAE DAVID</u>				4. DATE OF DEATH Month Day Year <u>JAN 28 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 7 1923</u>	
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Cummings</u>				14. MOTHER'S MAIDEN NAME <u>Ann MORAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>58224673</u>		17. INFORMANT Address <u>HENRY DAVID-5207-29th AN-HILL CREST HTS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcomatous</u> <u>196X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chondro-sarcoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1951</u> , 1951, to <u>28 Jan</u> , 1957, that I last saw the deceased alive on <u>26 Jan</u> , 1957, and that death occurred at <u>4:50 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Edward L. Wilson Jr</u> M.D. <u>1801-Exp. B. N.W. Wash. D.C.</u> 28 Jan 57							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan 31, 1957</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Lee Sons Co - 300 - 4th St. N.W.</u>				24a. REC'D BY REGISTRAR <u>Jan 30, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>Feb 3 1957</i>
AGE <i>45</i>		SEX <i>M</i>
RACE <i>W</i>		EDUCATION <i>High School</i>
OCCUPATION <i>Teacher</i>		RESIDENCE <i>123 Main St, Baltimore, Md</i>
CAUSE OF DEATH <i>Heart Disease</i>		PLACE OF DEATH <i>Home</i>
DATE OF BURIAL <i>Feb 5 1957</i>		PLACE OF BURIAL <i>Greenwood Cemetery</i>
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF REGISTRAR <i>[Signature]</i>
DATE OF SIGNATURE <i>Feb 4 1957</i>		DATE OF SIGNATURE <i>Feb 4 1957</i>

BUREAU V. S.

FEB 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1011

CERTIFICATE OF DEATH

00946

Reg. Dist. No. 243

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLENN DALE</u>				c. LENGTH OF STAY IN 1b <u>1 yr. 4 mo., 15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GLENN DALE HOSPITAL</u>				d. STREET ADDRESS <u>845 HOWARD ROAD S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>T</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 13, 1887</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>69</u> Days <u>69</u> Hours <u>69</u> Min. <u>69</u>		IF UNDER 24 HRS. Months <u>69</u> Days <u>69</u> Hours <u>69</u> Min. <u>69</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charlie Davis</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>lost</u>		17. INFORMANT Address <u>Decedent</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>002X</u> (b) <u>Senile arteriosclerotic nephrosclerosis</u> (c) <u>2 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) Arteriosclerotic heart disease; 2) pulmonary tuberculosis, 4 yrs</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>8 months.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>8 months.</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>9/12/55</u> , 19 <u>55</u> , to <u>1/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/26/57</u> , 19 <u>57</u> , and that death occurred at <u>10:30 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital, Glenn Dale, Md.</u> DATE SIGNED <u>1/26/57</u> ACTUAL SIGNATURE <u>Daniel Leo Finucane</u> M.D. PHYSICIAN'S NAME (Type) <u>Daniel Leo Finucane</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Howard Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Unity Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Shanden</u> ADDRESS <u>Rockville Md.</u>				24a. REC'D BY REGISTRAR <u>1/26/57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Weiss</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

NAME OF DECEASED <i>JOHN J. SMITH</i>		DATE OF DEATH <i>FEB 1 1957</i>	
PLACE OF DEATH <i>HOME</i>		MANNER OF DEATH <i>NATURAL</i>	
AGE <i>65</i>		SEX <i>MALE</i>	
RACE <i>WHITE</i>		EDUCATION <i>HIGH SCHOOL</i>	
OCCUPATION <i>CLERK</i>		MARITAL STATUS <i>MARRIED</i>	
BIRTH DATE <i>1891</i>		BIRTH PLACE <i>MARYLAND</i>	
FATHER'S NAME <i>JOHN J. SMITH</i>		MOTHER'S NAME <i>MARY J. SMITH</i>	
PREVIOUS ILLNESS <i>HEART DISEASE</i>		CAUSE OF DEATH <i>HEART DISEASE</i>	
IMMEDIATE CAUSE <i>HEART DISEASE</i>		MIDDLE CAUSE <i>HEART DISEASE</i>	
FUNDAMENTAL CAUSE <i>HEART DISEASE</i>		OTHER CAUSE <i>HEART DISEASE</i>	
SIGNATURE OF PHYSICIAN <i>JOHN J. SMITH</i>		SIGNATURE OF DEATH REGISTRAR <i>JOHN J. SMITH</i>	
DATE OF SIGNATURE <i>FEB 1 1957</i>		DATE OF SIGNATURE <i>FEB 1 1957</i>	

RECEIVED
 FEB 1 1957
 BUREAU V. 2

RECEIVED

949

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md.</u>		c. LENGTH OF STAY IN 1b <u>26 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville Md.</u>		d. STREET ADDRESS <u>5508 44th Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Degges</u> Last		4. DATE OF DEATH Month <u>Jan.</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-13-85</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sanitary Comm.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Henry Degges</u>		14. MOTHER'S MAIDEN NAME <u>Betty May Hill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Alice (Wife)</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General arteriosclerosis.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-4</u> , 19 <u>53</u> , to <u>1-19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-18</u> , 19 <u>57</u> , and that death occurred at <u>9:35 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>1-19-57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. A Deitz</u>		ADDRESS <u>Hyattsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/22/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>JAN 23 57</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

910

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. RACE [REDACTED]	
5. DATE OF BIRTH [REDACTED]		6. PLACE OF BIRTH [REDACTED]	
7. DATE OF DEATH [REDACTED]		8. PLACE OF DEATH [REDACTED]	
9. TIME OF DEATH [REDACTED]		10. CAUSE OF DEATH [REDACTED]	
11. MANNER OF DEATH [REDACTED]		12. SIGNATURE OF PHYSICIAN [REDACTED]	
13. SIGNATURE OF REGISTRAR [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]	

BUREAU V. 5

JAN 23 1957

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT OF 1946, CHAP. 23, SECT. 1-10, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT OF 1950, CHAP. 23, SECT. 1-10, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT OF 1955, CHAP. 23, SECT. 1-10.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

950

CERTIFICATE OF DEATH

00948

Reg. Dist. No.

245

1. PLACE OF DEATH o. COUNTY <u>Prince George County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>				d. STREET ADDRESS <u>3900 Hamilton St</u> # <u>101</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>ALONZO</u> Last <u>Demarr</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-1-1881</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian of Press</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>			
13. FATHER'S NAME <u>James J. Demarr</u>				14. MOTHER'S MAIDEN NAME <u>Victoria La Marr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal Bronchopneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>57</u> , to <u>Jan 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 19</u> , 19 <u>57</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ronald S. Fleischer</u> M.D.				ADDRESS (Street, city or town, state) <u>1432 QUEENS CHAPEL Rd</u> DATE SIGNED <u>1/24/57</u>			
PHYSICIAN'S NAME (Type) <u>RONALD S. FLEISCHER</u>				ADDRESS <u>HYATTSVILLE Rd</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Dorsch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 24 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>James E. Kover</u>							

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JAN 24 1957
BUREAU V. 8

1012

CERTIFICATE OF DEATH

00949

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>PG</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aquasco</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Aquasco</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>life</u>				d. STREET ADDRESS <u>life</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES LYNNELL DOUGLAS</u>				4. DATE OF DEATH Month Day Year <u>JAN 12 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 11, 1926</u>	
9. AGE (In years last birthday) <u>1 mo</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Calvin Smallwood</u>				14. MOTHER'S MAIDEN NAME <u>Allice Rebecca Douglas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>life</u>		17. INFORMANT <u>Allice Rebecca Douglas - Aquasco Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>500x Acute Infection Bronchitis</u> DUE TO <u>life</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sm. Throat cold</u> DUE TO <u>life</u> (c) <u>Cold</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>2 days</u> <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 11, 1957</u> , to <u>Jan 12, 1957</u> , that I last saw the deceased alive on <u>Jan 11, 1957</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>V. M. Seron</u>				ADDRESS (Street, city or town, state) <u>Aquasco Md</u>			
PHYSICIAN'S NAME (Type) <u>V. M. SERON MD</u>				DATE SIGNED <u>1/12/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Philip's</u>		22d. LOCATION (City, town, or county) (State) <u>Aquasco Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert Inwood Home - Washington, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	
DATE <u>JAN 21 1957</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed in 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

Jan 21 1957

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Race</p>	
<p>4. Date of birth</p>		<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>		<p>9. Place of death</p>	
<p>10. Signature of physician</p>		<p>11. Signature of registrar</p>		<p>12. Signature of informant</p>	
<p>13. Date of registration</p>		<p>14. Place of registration</p>		<p>15. Date of filing</p>	
<p>16. Date of burial</p>		<p>17. Place of burial</p>		<p>18. Date of cremation</p>	
<p>19. Date of interment</p>		<p>20. Place of interment</p>		<p>21. Date of exhumation</p>	
<p>22. Date of reinterment</p>		<p>23. Place of reinterment</p>		<p>24. Date of removal</p>	
<p>25. Date of return</p>		<p>26. Place of return</p>		<p>27. Date of disposal</p>	
<p>28. Date of disposal</p>		<p>29. Place of disposal</p>		<p>30. Date of disposal</p>	
<p>31. Date of disposal</p>		<p>32. Place of disposal</p>		<p>33. Date of disposal</p>	
<p>34. Date of disposal</p>		<p>35. Place of disposal</p>		<p>36. Date of disposal</p>	
<p>37. Date of disposal</p>		<p>38. Place of disposal</p>		<p>39. Date of disposal</p>	
<p>40. Date of disposal</p>		<p>41. Place of disposal</p>		<p>42. Date of disposal</p>	
<p>43. Date of disposal</p>		<p>44. Place of disposal</p>		<p>45. Date of disposal</p>	
<p>46. Date of disposal</p>		<p>47. Place of disposal</p>		<p>48. Date of disposal</p>	
<p>49. Date of disposal</p>		<p>50. Place of disposal</p>		<p>51. Date of disposal</p>	
<p>52. Date of disposal</p>		<p>53. Place of disposal</p>		<p>54. Date of disposal</p>	
<p>55. Date of disposal</p>		<p>56. Place of disposal</p>		<p>57. Date of disposal</p>	
<p>58. Date of disposal</p>		<p>59. Place of disposal</p>		<p>60. Date of disposal</p>	
<p>61. Date of disposal</p>		<p>62. Place of disposal</p>		<p>63. Date of disposal</p>	
<p>64. Date of disposal</p>		<p>65. Place of disposal</p>		<p>66. Date of disposal</p>	
<p>67. Date of disposal</p>		<p>68. Place of disposal</p>		<p>69. Date of disposal</p>	
<p>70. Date of disposal</p>		<p>71. Place of disposal</p>		<p>72. Date of disposal</p>	
<p>73. Date of disposal</p>		<p>74. Place of disposal</p>		<p>75. Date of disposal</p>	
<p>76. Date of disposal</p>		<p>77. Place of disposal</p>		<p>78. Date of disposal</p>	
<p>79. Date of disposal</p>		<p>80. Place of disposal</p>		<p>81. Date of disposal</p>	
<p>82. Date of disposal</p>		<p>83. Place of disposal</p>		<p>84. Date of disposal</p>	
<p>85. Date of disposal</p>		<p>86. Place of disposal</p>		<p>87. Date of disposal</p>	
<p>88. Date of disposal</p>		<p>89. Place of disposal</p>		<p>90. Date of disposal</p>	
<p>89. Date of disposal</p>		<p>90. Place of disposal</p>		<p>91. Date of disposal</p>	
<p>90. Date of disposal</p>		<p>91. Place of disposal</p>		<p>92. Date of disposal</p>	
<p>91. Date of disposal</p>		<p>92. Place of disposal</p>		<p>93. Date of disposal</p>	
<p>92. Date of disposal</p>		<p>93. Place of disposal</p>		<p>94. Date of disposal</p>	
<p>93. Date of disposal</p>		<p>94. Place of disposal</p>		<p>95. Date of disposal</p>	
<p>94. Date of disposal</p>		<p>95. Place of disposal</p>		<p>96. Date of disposal</p>	
<p>95. Date of disposal</p>		<p>96. Place of disposal</p>		<p>97. Date of disposal</p>	
<p>96. Date of disposal</p>		<p>97. Place of disposal</p>		<p>98. Date of disposal</p>	
<p>97. Date of disposal</p>		<p>98. Place of disposal</p>		<p>99. Date of disposal</p>	
<p>98. Date of disposal</p>		<p>99. Place of disposal</p>		<p>100. Date of disposal</p>	

BUREAU V. E.

JAN 21 1957

RECEIVED

100-27-24

Howe, Henry of Maine

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

927

CERTIFICATE OF DEATH

Reg. Dist. No.

00950

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7307 Forest Rd.</u>		d. STREET ADDRESS <u>7307 Forest Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Olivia</u> Last <u>Everett</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug 13, 1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Robert Thomson</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Cross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>042-078808</u>	
17. INFORMANT <u>Eunice S. Hutchison</u>		Address <u>7402 N. Hampshire</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-vascular Disease</u> DUE TO <u>5 yrs.</u> (c) <u>1 month</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. 11.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>23 Jan.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>22 Jan.</u> , 19 <u>57</u> , and that death occurred at <u>8 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas M. Hutchison</u>		ADDRESS (Street, city or town, state) <u>7315 Landover Rd Hyattsville, Md</u>	
PHYSICIAN'S NAME (Type) <u>James M. Hutchison</u>		DATE SIGNED <u>1-23-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James M. Hutchison</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 28 1957

RECEIVED

951

CERTIFICATE OF DEATH

Reg. Dist. No.

745

1. PLACE OF DEATH a. COUNTY <i>Prince Geo.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville Cheverly</i>		c. LENGTH OF STAY IN 1b <i>30 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Geo. Gen. Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Ellen</i> Last <i>Fallon</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>3</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7 June 1922</i>
9. AGE (In years last birthday) <i>34</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wash. D.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Jack Burke</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Fletcher</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Thos A. Fallon</i>		Address <i>7714-82nd Ave Hyattsville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cirrhosis of Liver</i> <i>581.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>2 Months</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>a. p.</i> <i>19</i> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>15 Nov</i> , 1956, to <i>3 Jan</i> , 1957, that I last saw the deceased alive on <i>3 Jan</i> , 1957, and that death occurred at <i>9:50 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>7315 Landover Rd Hyattsville Md</i> DATE SIGNED <i>Jan 7 1957</i> ACTUAL SIGNATURE <i>Thomas M. Hutchins</i> M.D. <i>7315 Landover Rd Hyattsville Md</i> PHYSICIAN'S NAME (Type) <i>THOMAS M. HUTCHINS 7315 LANDOVER RD HYATTSVILLE MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Jan 7, 1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Washington National</i>	22d. LOCATION (City, town, or county) (State) <i>Landover Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>LEE FUNERAL HOME</i>		24a. REC'D BY REGISTRAR <i>James</i>	
ADDRESS <i>300 4th Ave</i>		24b. REGISTRAR'S SIGNATURE <i>James</i>	
DATE <i>JAN 7 1957</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00952

Reg. Dist. No.

1013

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park</u> c. LENGTH OF STAY IN 1b <u>3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6409 Buchanan St</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park</u> d. STREET ADDRESS <u>16409-Buchanan St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Joseph</u> Last <u>Farrell</u>				4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 31, 1891</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stereotypist</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>				11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Michael Farrell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gaynor</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>577-16-5639</u>		17. INFORMANT <u>Dorothy Farrell, same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO <u>Pulmonary tuberculosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO <u> </u> (c) <u> </u> </div> <div style="width: 35%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u> </u> </div> </div>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>January 10, 1957</u>					
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Washington</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for various conditions and a large area for narrative notes.

BUREAU V. S.

JAN 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

952

CERTIFICATE OF DEATH

Reg. Dist. 00953

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANDOVER			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.				d. STREET ADDRESS 6100 OTIS ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELBERTIE Middle FOUDRAY Last FOUDRAY				4. DATE OF DEATH Month 1-16 Day 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-30-78	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) U.S.A.	
10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Elbert Foudray		14. MOTHER'S MAIDEN NAME Mary Poundstone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 161X		17. INFORMANT Felix Foudray Address 3301 Chatham Rd. Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO 161X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of larynx DUE TO (c) 3 yr				INTERVAL BETWEEN ONSET AND DEATH 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-11-56 , 19 56 to 1-16 , 19 57 , that I last saw the deceased alive on 1-16-57 , 19 57 , and that death occurred at 12:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John Kehoe M.D.				DATE SIGNED Jan 21 57			
PHYSICIAN'S NAME (Type) JOHN KEHOE				DATE SIGNED Jan 21 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-19-57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee's Sons Co ADDRESS 300 1st N.E. D.C.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Overman	

CERTIFICATE OF DEATH

023

1957

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 21 1957	
AGE		SEX	
75		M	
DATE OF BIRTH		PLACE OF BIRTH	
JAN 21 1882		JAN 21 1882	
MARRIAGE		MARRIAGE	
MARRIED		MARRIED	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
JAN 21 1900		JAN 21 1900	
OCCUPATION		OCCUPATION	
FARMER		FARMER	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
PLACE OF DEATH		PLACE OF DEATH	
HOME		HOME	
DATE OF INTERMENT		DATE OF INTERMENT	
JAN 21 1957		JAN 21 1957	
PLACE OF INTERMENT		PLACE OF INTERMENT	
CATHOLIC CHURCH		CATHOLIC CHURCH	
NAME OF MINISTER		NAME OF MINISTER	
JAMES H. HARRIS		JAMES H. HARRIS	
NAME OF FUNERAL HOME		NAME OF FUNERAL HOME	
JAMES H. HARRIS		JAMES H. HARRIS	
NAME OF BURIAL PLACE		NAME OF BURIAL PLACE	
CATHOLIC CHURCH		CATHOLIC CHURCH	
NAME OF BURIAL PLACE		NAME OF BURIAL PLACE	
CATHOLIC CHURCH		CATHOLIC CHURCH	

BUREAU V. E.

JAN 21 1957

RECEIVED

953

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>16</u> days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Carr</u> Last <u>Gambrill</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>14-10-1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>80</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Arthur Carr</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Hardesty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Wellstood White Dickerson, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Carcinoma of Gall Bladder</u> <u>155X</u> DUE TO <u>with multiple metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cholelithiasis (3 large stones)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 month + P</u> <u>P</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-8</u> , 19 <u>57</u> , to <u>1-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-28</u> , 19 <u>57</u> , and that death occurred at <u>1:00</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Waldo B. Moyers</u> M.D. <u>MT. RAINIER, MD.</u> <u>1-25-57</u>							
ACTUAL SIGNATURE <u>Waldo B. Moyers</u> M.D. <u>MT. RAINIER, MD.</u>							
PHYSICIAN'S NAME (Type) <u>Dr. W. Moyers</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St James Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tracy Landing, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Paschke Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 1 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1014

CERTIFICATE OF DEATH

00955

Reg. Dist. No. 243

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)				c. LENGTH OF STAY IN 1b 1 yr. 10 mo.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle G. Last Gath				4. DATE OF DEATH Month Jan. Day 15 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/3/1887	
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Gath				14. MOTHER'S MAIDEN NAME Jennie P. Steele			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic cor pulmonale 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Pulmonary tuberculosis DUE TO (c) 14 yrs.						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4343						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Washington		(County) (State)	
21. I certify that I attended the deceased from 2/18/55 , 19____, to 1/15 , 19 57 , that I last saw the deceased alive on 1/15 , 19 57 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Daniel Leo Finucane M.D.				ADDRESS (Street, city or town, state) Glenn Dale Hospital, Glenn Dale, Md.			
DATE SIGNED 1/15/57							
PHYSICIAN'S NAME (Type) Daniel Leo Finucane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/15/57		22c. NAME OF CEMETERY OR CREMATORY Washington		22d. LOCATION (City, town, or county) (State) DC.	
23. FUNERAL DIRECTOR'S SIGNATURE 20 W. Chambers B. 517-11th St. S.E. #44				ADDRESS 517-11th St. S.E. #44		24a. REC'D BY REGISTRAR DATE 1/15/57	
				24b. REGISTRAR'S SIGNATURE W. W. Weir			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
NAME OF REGISTRAR		ADDRESS OF REGISTRAR	
NAME OF PHYSICIAN		ADDRESS OF PHYSICIAN	
NAME OF WITNESS		ADDRESS OF WITNESS	
NAME OF SECOND WITNESS		ADDRESS OF SECOND WITNESS	
NAME OF THIRD WITNESS		ADDRESS OF THIRD WITNESS	
NAME OF FOURTH WITNESS		ADDRESS OF FOURTH WITNESS	
NAME OF FIFTH WITNESS		ADDRESS OF FIFTH WITNESS	
NAME OF SIXTH WITNESS		ADDRESS OF SIXTH WITNESS	
NAME OF SEVENTH WITNESS		ADDRESS OF SEVENTH WITNESS	
NAME OF EIGHTH WITNESS		ADDRESS OF EIGHTH WITNESS	
NAME OF NINTH WITNESS		ADDRESS OF NINTH WITNESS	
NAME OF TENTH WITNESS		ADDRESS OF TENTH WITNESS	

BUREAU V. 1

IAN 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 20 Film 212 3-27-57 a.m.											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 00956											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 478-3 Washington					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital						d. STREET ADDRESS 1444 N. Street N.W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Owen Last Glass						4. DATE OF DEATH Month January Day 20 Year 19 57					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-3-1900		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter & paper-hanger				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Sam Glass						14. MOTHER'S MAIDEN NAME Lucy Mills					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Walter S. Glass; Bremo Bluff, Virginia.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral compression DUE TO Conditions, if any, which gave rise to immediate cause (b) Intracranial hemorrhage (c), stating the underlying cause lost. Cerebral laceration and fractured skull											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pending											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown at the present time. Details may never be known.							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D.						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 20, 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/23/57		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery			22d. LOCATION (City, town, or county) (State) Fluvanin County Va.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland						24a. REC'D BY REGISTRAR DATE 3 1957		24b. REGISTRAR'S SIGNATURE James Secor			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John V. Egan, M.D.	
Sex		Male	
Age		3-3-1900	
Race		White	
Birthplace		Ireland	
Residence		1111 W. Street, N.W.	
Occupation		Physician	
Cause of Death		Heart Failure	
Manner of Death		Natural	
Date of Death		January 28, 1957	
Time of Death		10:00 AM	
Place of Death		Home	
Signature of Medical Examiner		John V. Egan, M.D.	

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JAN 29 1957
BUREAU V. 1

Name of Medical Examiner		John V. Egan, M.D.	
Address of Medical Examiner		1111 W. Street, N.W.	
Signature of Medical Examiner		John V. Egan, M.D.	
Date of Certificate		January 28, 1957	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1015

CERTIFICATE OF DEATH

Reg. Dist. No.

00957

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. LENGTH OF STAY IN 1b <u>5 yr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>Brandywine me</u>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Hillegree</u> Last <u>Wood</u>		9. DATE OF DEATH Month <u>Jan</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 15, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Denver, Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Andrew Hillegree</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hillegree</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Wm. Denny Dore</u>		Address <u>Brandywine me</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aeroma</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Interference Cardio-vascular-Respiratory</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>yro</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>-</u> 19 p. m. <u>-</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State) <u>-</u>	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-12</u> , 19 <u>57</u> , and that death occurred at <u>9:00</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Brandywine me</u> <u>1-12-57</u>			
ACTUAL SIGNATURE <u>Richard H. Dabson</u> M.D.		PHYSICIAN'S NAME (Type) <u>Richard H. Dabson</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-13-1957</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Joseph Sawler's Sons, Wash., D.C.</u>		22d. LOCATION (City, town, or county) (State) <u>ADELPHIA, MONMOUTH, NEW JERSEY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawler's Sons, Wash., D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 21 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>H. H. Hedrick</u>			

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. MANNER OF DEATH	
At Home		Natural	
3. SEX		4. AGE	
Male		65	
5. RACE		6. COLOR	
White		White	
7. BIRTH DATE		8. BIRTH PLACE	
Jan 1, 1900		Maryland	
9. OCCUPATION		10. EDUCATION	
Farmer		High School	
11. MARITAL STATUS		12. PRESENT RESIDENCE	
Married		1234 Main St, Baltimore, Md	
13. DATE OF DEATH		14. TIME OF DEATH	
Jan 21, 1957		10:00 AM	
15. CAUSE OF DEATH		16. MEDICAL HISTORY	
Heart Disease		Hypertension	
17. PRESENT ILLNESS		18. PREVIOUS ILLNESS	
Chest Pain		Stroke	
19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	
21. PHYSICIAN'S ADDRESS		22. REGISTRAR'S ADDRESS	
123 Main St, Baltimore, Md		456 Main St, Baltimore, Md	

BUREAU V. 3

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 2, 9 FilmCell 2-25-57 et

Reg. Dist. No.

00858

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B. & O. Railroad Crossing, Queensbury Rd.		d. STREET ADDRESS 6104 Rhode Island Avenue	
3. NAME OF DECEASED (Type or print) Daisy Hardy		4. DATE OF DEATH January 29, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 14, 1872
9. AGE (In years last birthday) 84 7/8 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Ross		14. MOTHER'S MAIDEN NAME Ann Edrington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Herminia James Tenofly New Jersey		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Fractured skull and multiple fractures of body. (c) 802x DUE TO (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was struck by Batl. and Ohio Train No. 687 while she was walking across track	
20c. TIME OF INJURY Month, Day, Year 1-29-57 Hour 3:22 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/> R.R. Tracks	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Riverdale		20f. (City or town) (County) (State) Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/57	
22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		ADDRESS	
24a. REC'D BY REGISTRAR FEB 6 1957		24b. REGISTRAR'S SIGNATURE James E. Seawey	

MEDICAL CERTIFICATION

16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please give the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

FEB 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 14 FilmG210 2-1-57 et
956
CERTIFICATE OF DEATH

Reg. Dist. No. 00959

1. PLACE OF DEATH o. COUNTY <u>Prinde George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New York</u> b. COUNTY <u>Syracuse</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. STREET ADDRESS <u>248 Elk Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Harris</u> Last <u>Harris</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 Dec. 1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>63</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			
11. BIRTHPLACE (State or foreign country) <u>Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Simon Simon</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>420.1</u>			
17. INFORMANT <u>Husband</u>				Address <u>7206 Colesville Rd, University Hills</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Necrosis</u> DUE TO <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> (c) <u>Generalized Atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12-14</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Hyattsville, Md.</u>				20g. (County) <u>Prince George's</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Jan 14, 1957</u> to <u>Jan 19, 1957</u> , that I last saw the deceased alive on <u>Jan 19, 1957</u> , and that death occurred at <u>11:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. Deitz</u>				ADDRESS (Street, city or town, state) <u>4314 Galtier-Hyattsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. Deitz</u>				DATE SIGNED <u>1-20-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 21, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Temple Sinai</u>		22d. LOCATION (City, town, or county) (State) <u>Hyatts, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Danzansky</u>				ADDRESS <u>3501 14th St. N.W., Wash., D.C.</u>		24a. REC'D BY REGISTRAR <u>Jan 28 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 28 1957

RECEIVED

DEPT. OF HEALTH

A. DILL

JAN 21 1957

3501 E. BALTIMORE

18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1016 Item 7, Film G210, 2/4/57 bh

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Piscataway		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Floral Park Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Edward Last Harrison		4. DATE OF DEATH Month January Day 21 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1930
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months 26 Days 26 Hours 26 Min.	IF UNDER 24 HRS. Hours 26 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Hauling	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Harrison		14. MOTHER'S MAIDEN NAME Louise Edwards	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Louise Harrison (Mother)		Address Same add., As # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 823X IMMEDIATE CAUSE (a) Universal Charring Burns of the body DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile that ran off the road and caught on fire	
20c. TIME OF INJURY Month, Day, Year 7:00 a. m. 3/ 21, 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Piscataway P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED January 21, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/24/57	
22c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		22d. LOCATION (City, town, or county) (State) Wayside Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arehart Inc. Laplata, Maryland		24a. REC'D BY REGISTRAR 1/24/57	
24b. REGISTRAR'S SIGNATURE James H. Pansy		24c. REGISTRAR'S SIGNATURE Carrie Campbell	

0096034

RECEIVED

1992

1992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00961

CERTIFICATE OF DEATH

Reg. Dist. No.

730

925

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5014 Iroquois Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle L Last HATHAWAY		4. DATE OF DEATH Month January Day 30th, Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-1870
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY At home	
11c. BIRTHPLACE (State or foreign country) MAINE		11d. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER STURTEVANT		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Shirley R. Jackson, 5014 Iroquois St. College Park, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral Thrombosis DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. 9049 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture, Left Hip, (4 mos. old)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) College Park, Md.		(County) (State)	
21. I certify that I attended the deceased from Sept. 27, 1956, to Jan. 20, 1957, that I last saw the deceased alive on Jan. 28, 1957, and that death occurred at 5:00 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. A. Holbrook, M.D.		ADDRESS (Street, city or town, state) 4500 College Ave. College Park, Md.	
DATE SIGNED 1/30/57		22a. NAME OF CEMETERY OR CREMATOR Mt. Auburn Cemetery	
22b. LOCATION (City, town, or county) Auburn, Maine		(State)	
22c. DATE THEREOF Feb. 1, 1957		22d. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.	
22e. REC'D BY REGISTRAR DATE FEB 4 1957		22f. REGISTRAR'S SIGNATURE John D. Smith	

FEB -4 1957

RECEIVED

930

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier Md.</u>				c. LENGTH OF STAY IN 1b <u>6 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4004 32th Street</u>				e. STREET ADDRESS <u>4004 32th St</u>			
3. NAME OF DECEASED (Type or print) First <u>Bert</u> Middle <u>Calvin</u> Last <u>Havens</u>				4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7, 1872</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Butcher</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Nellie Peach</u> Address <u>Mt Rainier, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary embolus</u> <u>467.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic obliterative vascular disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>immed.</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec.</u> 19 <u>51</u> to <u>Jan.</u> 19 <u>56</u> that I last saw the deceased alive on <u>Jan. 22,</u> 19 <u>57</u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Benjamin S. Miller</u> M.D.				PHYSICIAN'S NAME (Type) <u>Benjamin S. Miller M.D.</u> <u>3824-34th St., Mt. Rainier, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>1/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chicago,</u>		22d. LOCATION (City, town, or county) (State) <u>Illinois</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 25 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>James Leary</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 25 1957

BUREAU V. S.

1017

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AQUASCO</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Aquasco</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>HOLLAND</u> Last <u>HOLLAND</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 16, 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Prince Geo Co - Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Holland</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Meades</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Clara Holland - Aquasco Md</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO <u>Chronic Heart Trouble</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yrs</u> <u>years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nor while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1957</u> to <u>Jan 16, 1957</u> that I last saw the deceased alive on <u>Jan 15, 1957</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vahen M. Seron MD</u>		ADDRESS (Street, city or town, state) <u>Aquasco Md</u>	
PHYSICIAN'S NAME (Type) <u>VAHEN M. SERON MD</u>		DATE SIGNED <u>1/16/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-19-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Thomas Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Aquasco, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u>		ADDRESS <u>Waldorf, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. F. Reduch</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		Male		35		White		April 22, 1928		Memphis, Tennessee		April 4, 1968		Memphis, Tennessee		Suicide		Suicide		James Earl Ray		James Earl Ray	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Attorney		High School		Single		Catholic		None		None		None		None		None		None		None		None	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray		James Earl Ray	

BUREAU V. 1

JAN 21 1957

RECEIVED

ST. JAMES CHURCH

1-12-57

The Hunt Funeral Home, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00964

957

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pr. Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hosp.</u>		e. STREET ADDRESS <u>2626 Kirkwood Pl.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Louise</u> Last <u>Hope</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3/1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired housewife - father</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D. C.</u>	
11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Henry Hodges</u>		14. MOTHER'S MAIDEN NAME <u>Mary Atee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or date of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hosp. records</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive heart failure</u>			
(b) <u>arteriosclerotic heart dis.</u> DUE TO <u></u>			
(c) <u></u> DUE TO <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. f. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-10-</u> 19 <u>57</u> , to <u>1-10-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>1-10-</u> 19 <u>57</u> , and that death occurred at <u>1045</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. W. Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Riverdale, Md.</u> DATE SIGNED <u>1/19/57</u>	
PHYSICIAN'S NAME (Type) <u>L. W. Malin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/14/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>Riverdale, Md.</u>		24a. REC'D BY REGISTRAR <u>JAMES SEVERY</u> DATE <u>JAN 14 1957</u>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

958

CERTIFICATE OF DEATH

00965

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Foote	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Gen. Hosp.		d. STREET ADDRESS 6651--Oxon Hill Rd., S.E.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle A. Last HUNGERFORD		4. DATE OF DEATH Month Jan. Day 18 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28th. 1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tractor Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathaniel Hungerford		14. MOTHER'S MAIDEN NAME Katie Fitzgerald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Susie E. Hungerford		Address -6651- Oxon Hill Road S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Post Nasal Hemorrhage with aspiration DUE TO (b) Carcinoma of Prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days 9 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/7/57, 1957, to 1/18, 1957, that I last saw the deceased alive on 1/18, 1957, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE John T. Lynn M.D. 5241 St. Barnabas Rd SE 1/18/57 PHYSICIAN'S NAME (Type) John T. Lynn MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 21- 57	
22c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery		22d. LOCATION (City, town, or county) (State) Oxon Hill, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE JAN 23 57	
24b. REGISTRAR'S SIGNATURE			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
959
CERTIFICATE OF DEATH

00966

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage 13X22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>		d. STREET ADDRESS <u>15 Baltimore St</u>	
3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>Wayne</u> Last <u>Jenkins</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 29 - '56</u>
9. AGE (In years lost birthday) yrs. <u>2</u> Months <u>8</u> Days <u>8</u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Md Balto. City</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert Jenkins</u>	
14. MOTHER'S MAIDEN NAME <u>Mary O'Keefe</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infantile Diarrhea primary</u> <u>041X</u> DUE TO <u>Due to Para typhoid</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>57</u> to <u>Jan 6</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>57</u> , and that death occurred at <u>8:40</u> A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>311 Thomas Drive Laurel Md</u>	
ACTUAL SIGNATURE <u>Robert C. Wingfield</u> M.D.		DATE SIGNED <u>Jan 8 - 57</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Savage Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Donaldson</u>		ADDRESS <u>Laurel Md</u>	
24. REC'D BY REGISTRAR <u>Jan 10 1957</u>		25. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>	

2137171XV6

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES J. JAMES		JAN 14 1957	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
MARRIAGE		OCCUPATION	
M		C	
PLACE OF BIRTH		PLACE OF DEATH	
MASSACHUSETTS		MASSACHUSETTS	
CITY OF BIRTH		CITY OF DEATH	
BOSTON		BOSTON	
DATE OF BIRTH		DATE OF DEATH	
JAN 14 1957		JAN 14 1957	
TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE	
MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION	
DURATION OF ILLNESS		DURATION OF ILLNESS	
2 WEEKS		2 WEEKS	
PLACE OF BIRTH		PLACE OF DEATH	
MASSACHUSETTS		MASSACHUSETTS	
CITY OF BIRTH		CITY OF DEATH	
BOSTON		BOSTON	
DATE OF BIRTH		DATE OF DEATH	
JAN 14 1957		JAN 14 1957	
TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE	
MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION	
DURATION OF ILLNESS		DURATION OF ILLNESS	
2 WEEKS		2 WEEKS	

RECEIVED
 JAN 14 1957
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director or page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

960

CERTIFICATE OF DEATH

00967

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 LAUREL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LELAND MEMORIAL HOSPITAL				d. STREET ADDRESS 307 COMPTON AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LAURA Middle JANE Last JENKINS				4. DATE OF DEATH Month JAN Day 18 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 6 1883		9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME SAMUEL FRYE				14. MOTHER'S MAIDEN NAME LAURA JANE HICKMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. _____		17. INFORMANT HARRIET UPDIKE Address LAUREL 307 COMPTON AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION SEVERE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5 HOURS 20 YRS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JAN. 18, 1957 , to JAN. 18, 1957 , that I last saw the deceased alive on JAN 18, 1957 , and that death occurred at 3:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. J. Houmann M.D. JAN. 18, 1957 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) C. J. HOUMANN 4404 QUEENSBURY RD. RIVERDALE MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Jan 20, 1957		Long Hill Cem.		Laurel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter H. Haskins				ADDRESS Laurel, Md.		24a. REC'D BY REGISTRAR DATE Jan 24 1957	
				24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN lb D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Beulah Gay Josephson				4. DATE OF DEATH January 14, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1921	
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Isaac B. Dunbar				14. MOTHER'S MAIDEN NAME Vida Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Walter H. Josephson; same address Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Fractured skull and crushed chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile collision			
20c. TIME OF INJURY Month, Day, Year 2:45 p.m. 1-14-1957				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Muirkirk, Pr. Geo.				20g. (County) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jan. 15, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				24a. REC'D BY REGISTRAR Jan 21 57		24b. REGISTRAR'S SIGNATURE W. H. Smith	

MEDICAL CERTIFICATION

99

16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

John T. Blaney

DATE OF DEATH

1957 JAN 21

1957 JAN 21

1957 JAN 21

1957 JAN 21

1957 JAN 21

1957 JAN 21

1957 JAN 21

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1957 JAN 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00969

1018

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 101- H. St., S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle M. Last Kelley		4. DATE OF DEATH Month Jan. Day 27 Year 19 57					
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/24/04				
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Frank Brown		14. MOTHER'S MAIDEN NAME Margaret Taylor					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Lost					
17. INFORMANT Decedent		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary tuberculosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day 5 yrs., 10mo							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from August 6 , 19 56 , to Jan. 27 , 19 57 , that I last saw the deceased alive on January 27 , 19 57 , and that death occurred at 3:20AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale, Maryland DATE SIGNED 1/27/57							
ACTUAL SIGNATURE Daniel Leo Finucane M.D.		PHYSICIAN'S NAME (Type) Daniel Leo Finucane					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1.28. 1957					
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington D.C.					
23. FUNERAL DIRECTOR'S SIGNATURE Barnes & Matthews		ADDRESS 614-4th SW Wash. D.C.					
24a. REC'D BY REGISTRAR DATE 1/27/57		24b. REGISTRAR'S SIGNATURE W. H. Wain					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

BUREAU V. S.

FEB 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00970 230

Reg. Dist. No.

1019

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Berwyn Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence 8514 Cunningham Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle FRANCES Last KIRBY				4. DATE OF DEATH Month January Day 27 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH January 19, 1866	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 0 Days 8 Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Fairfax Cty., Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Tobin				14. MOTHER'S MAIDEN NAME Laura Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Rosie B. Collins Address 8514 Cunningham Dr., Berwyn, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 PULMONARY Edema DUE TO (b) CHRONIC Congestive Heart Failure DUE TO (c) Generalized Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 1 day 1.2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 26, 1956, to Jan 31, 1957, that I last saw the deceased alive on Jan 26, 1957, and that death occurred at 4:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) WOLCOTT L. ETIENNE, M.D.				4713 Berwyn Rd., College Pk., Md. 1/27/57			
22a. BURIAL, CREMATION, REMOVAL, ETC. Burial		22b. DATE THEREOF 1/30/1957		22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		22d. LOCATION (City, town, or county) (State) Falls Church, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., ADDRESS Riverdale, Md.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of birth: <i>Jan 1, 1912</i></p>	
<p>5. Place of birth: <i>John Doe, Md.</i></p>		<p>6. Date of death: <i>Jan 29, 1957</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Place of death: <i>John Doe, Md.</i></p>	
<p>9. Signature of physician: <i>John Doe, M.D.</i></p>		<p>10. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>11. Date of registration: <i>Jan 29, 1957</i></p>		<p>12. Place of registration: <i>John Doe, Md.</i></p>	
<p>13. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>14. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>15. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>16. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>17. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>18. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>19. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>20. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>21. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>22. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>23. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>24. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>25. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>26. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>27. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>28. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>29. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>30. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>31. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>32. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>33. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>34. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>35. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>36. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>37. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>38. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>39. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>40. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>41. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>42. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>43. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>44. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>45. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>46. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>47. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>48. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>49. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>50. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>51. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>52. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>53. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>54. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>55. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>56. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>57. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>58. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>59. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>60. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>61. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>62. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>63. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>64. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>65. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>66. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>67. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>68. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>69. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>70. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>71. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>72. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>73. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>74. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>75. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>76. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>77. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>78. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>79. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>80. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>81. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>82. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>83. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>84. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>85. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>86. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>87. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>88. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>89. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>90. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>91. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>92. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>93. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>94. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>95. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>96. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>97. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>98. Signature of registrar: <i>John Doe, M.D.</i></p>	
<p>99. Signature of registrar: <i>John Doe, M.D.</i></p>		<p>100. Signature of registrar: <i>John Doe, M.D.</i></p>	

BUREAU V. S.

RECEIVED
JAN 29 1957

1020

CERTIFICATE OF DEATH

Reg. Dist. No.

r30

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights c. LENGTH OF STAY IN 1b 4 Months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8613 Quebec St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 X-3 d. STREET ADDRESS 1529 Upshur St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry		4. DATE OF DEATH Month Jan. Day 3 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1887
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Painter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 121-22-0598	
17. INFORMANT Mrs Hennitta R Mc Dougald		Address Berwyn Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage due to Ca of lungs 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Inoperable Carcinoma of lungs. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sep 28 , 19 56 , to Dec 8 , 19 56 , that I last saw the deceased alive on Dec 8 , 19 56 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2015 Nichols ave SE Washington DC DATE SIGNED ACTUAL SIGNATURE Schwartzman M.D. PHYSICIAN'S NAME (Type) Dr A. Schwartzman			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/4/57	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR 1557		24b. REGISTRAR'S SIGNATURE John D. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Washington

1887

white

June 21, 1887

white

female

Self Employed

one father

unknown

unknown

1887-06-21

BUREAU V. S.

JAN 7 1957

RECEIVED

962

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince George County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3 Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>				d. STREET ADDRESS <u>2100 n st n.w Apts 2</u>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Gary</u> Last <u>bandon</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-29-85</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas E. bandon</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Tucker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>5 HRS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>—</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-7</u> , 19 <u>43</u> , to <u>1-27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-27-57</u> , 19 <u>57</u> , and that death occurred at <u>7:15</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. J. Houmann</u>				DATE SIGNED <u>1-27-57</u>			
PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN M.D.</u>				ADDRESS (Street, city or town, state) <u>4404 QUEENSBURY RD RIVERDALE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Switzerland</u>	
22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malling Funeral Home</u>				24. REGISTRAR'S SIGNATURE <u>James Seacra</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

1957 1 3

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

963

CERTIFICATE OF DEATH

00973

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ann REBECCA Larson				4. DATE OF DEATH Month Day Year January 9 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-8- -1886	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Eelen				14. MOTHER'S MAIDEN NAME Marie Dove			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Marie Adams 1316-Bryant St. N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 331X DUE TO Hypertension, arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1/3/57 to DUE TO (c) 1/9/57							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/18/57 to 1/8/57 , that I last saw the deceased alive on 1/8/57 , and that death occurred at 12:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Max W. Herzberg M.D. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) MAX M. HERZBERG, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-14-57		22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. W. Chambers Co. 517-11 St. N.E.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE On March	

RECEIVED

JAN 14 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **239**

00924
239

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14th Street, Rear of Laurel Furniture Co.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 2 Laurel	
3. NAME OF DECEASED (Type or print) First Robert Middle Warren Last Lilley		4. DATE OF DEATH Month January Day 12, Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-6-37
9. AGE (In years last birthday) 19 yrs.		10. IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min.	11. IF UNDER 24 HRS. Months 19 Days 19 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY college	
11. BIRTHPLACE (State or foreign country) Laurel		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leroy Lilley		14. MOTHER'S MAIDEN NAME Bertha Edmonston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-30-8270	
17. INFORMANT Frances Edmonston: same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 976x IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Gunshot wound of head Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gunshot wound of head DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound of head.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. Jan. 1957 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Laurel (County) Pr. Geo. (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> January 12, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF January 14, 1957	
22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		22d. LOCATION (City, town, or county) Laurel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert Donaldson		23a. REC'D BY REGISTRAR Jan 16 -	
ADDRESS Laurel Md		23b. REGISTRAR'S SIGNATURE M. J. Cashears	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

RESIDENCE: [illegible] STREET: [illegible] CITY: [illegible] STATE: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible] MANNER OF DEATH: [illegible]

POST-MORTEM EXAMINATION: [illegible] SIGNATURE OF EXAMINER: [illegible]

DATE OF EXAMINATION: [illegible] SIGNATURE OF WITNESS: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible] MANNER OF DEATH: [illegible]

POST-MORTEM EXAMINATION: [illegible] SIGNATURE OF EXAMINER: [illegible]

DATE OF EXAMINATION: [illegible] SIGNATURE OF WITNESS: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible] MANNER OF DEATH: [illegible]

POST-MORTEM EXAMINATION: [illegible] SIGNATURE OF EXAMINER: [illegible]

DATE OF EXAMINATION: [illegible] SIGNATURE OF WITNESS: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible] MANNER OF DEATH: [illegible]

POST-MORTEM EXAMINATION: [illegible] SIGNATURE OF EXAMINER: [illegible]

DATE OF EXAMINATION: [illegible] SIGNATURE OF WITNESS: [illegible]

BUREAU V. S.

AN 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

965

CERTIFICATE OF DEATH

00975

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 West Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR IN PRINCE GEORGE HOSPITAL		d. STREET ADDRESS 5002 36 th Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eunice Middle M. Last Lister		4. DATE OF DEATH Month Jan. Day 2 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/1900
9. AGE (In years and birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY in own home	
11. BIRTHPLACE (State or foreign country) Alexandria, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Nalley		14. MOTHER'S MAIDEN NAME Isabelle Carroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Josephine Wright (Daughter)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO Congested Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 29 1956, to Jan 2 1957, that I last saw the deceased alive on Jan 2 1957, and that death occurred at 7:20 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 30-C RIDGE Rd, Greenbelt, Md 1-3-57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Nalley's Funeral Home 2200 R.F. Ave Mt. Rainier, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/7/57	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Alexandria, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		24a. REC'D BY REGISTRAR JAN 8 57	
24b. REGISTRAR'S SIGNATURE A. L. Lister			

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]		9. MEDICAL HISTORY [REDACTED]	
10. OCCUPATION [REDACTED]		11. EDUCATION [REDACTED]		12. SOCIAL HISTORY [REDACTED]	
13. SIGNATURE OF PHYSICIAN [REDACTED]		14. SIGNATURE OF REGISTRAR [REDACTED]		15. SIGNATURE OF WITNESS [REDACTED]	
16. SIGNATURE OF DECEASED [REDACTED]		17. SIGNATURE OF NEXT OF KIN [REDACTED]		18. SIGNATURE OF BURIAL OFFICIAL [REDACTED]	
19. SIGNATURE OF CHURCH OFFICIAL [REDACTED]		20. SIGNATURE OF FUNERAL HOME [REDACTED]		21. SIGNATURE OF CEMETERY [REDACTED]	
22. SIGNATURE OF HEALTH DEPARTMENT [REDACTED]		23. SIGNATURE OF STATE DEPARTMENT OF HEALTH [REDACTED]		24. SIGNATURE OF NATIONAL BUREAU OF VITAL STATISTICS [REDACTED]	

BUREAU V. S.

JAN 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

966

CERTIFICATE OF DEATH

00976

Reg. Dist. No. 230

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		c. LENGTH OF STAY IN 1b 4 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 33--J--Ridge Road		e. STREET ADDRESS 33--J--Ridge Road	
3. NAME OF DECEASED (Type or print) First VICTOR Middle EMANUEL Last LOFGREN		4. DATE OF DEATH Month January Day 12th, Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25th, 1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY Steel Mill	
11. BIRTHPLACE (State or foreign country) McKeesport, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gustave Lifgren		14. MOTHER'S MAIDEN NAME Anna (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 175-12-5956	
17. INFORMANT Hildur M. Lifgren, 33-J Ridge Rd. Greenbelt, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebro-vascular accident DUE TO (b) cerebral arteriosclerosis DUE TO (c) lying cause lost CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1st Cerebro-vascular accident & paralysis onset - 2 years ago INTERVAL BETWEEN ONSET AND DEATH 30 yrs 6 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 11, 1955, to Jan 12, 1957, that I last saw the deceased alive on Jan 11, 1957, and that death occurred at 3:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE HANS WODAK M.D. 30-C RIDGE RD. GREENBELT, MD 17257 PHYSICIAN'S NAME (Type) HANS WODAK			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/1957	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE Jan 15-1957	
24b. REGISTRAR'S SIGNATURE John H. Smith			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		Male		35		White		1922		Memphis, Tennessee	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR	
April 4, 1968		10:00 AM		St. Louis, Missouri		Suicide		Homicide		[Signature]	
13. FULL NAME OF REGISTRAR		14. ADDRESS OF REGISTRAR		15. CITY AND STATE OF REGISTRAR		16. COUNTY OF REGISTRAR		17. ZIP CODE OF REGISTRAR		18. SIGNATURE OF REGISTRAR	
[Name]		[Address]		[City, State]		[County]		[ZIP]		[Signature]	
19. FULL NAME OF DECEASED		20. ADDRESS OF DECEASED		21. CITY AND STATE OF DECEASED		22. COUNTY OF DECEASED		23. ZIP CODE OF DECEASED		24. SIGNATURE OF DECEASED	
[Name]		[Address]		[City, State]		[County]		[ZIP]		[Signature]	

BUREAU V. 1

JAN 21 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00977

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheseddy		c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6904 George Palmer Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES Edward MACON				4. DATE OF DEATH January 17 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 9, 1931	9. AGE (In years last birthday) 25 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Early MACON				14. MOTHER'S MAIDEN NAME Annie Z. Pierce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Arleen MacON, 6511 Central Ave, Seat Pleasant, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0 DUE TO Shock and pulmonary congestion Conditions, if any, which gave rise to immediate cause (b) 80% second and third degree burns body (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY (a) OF CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Incapartment that burned					
20c. TIME OF INJURY Month, Day, Year 9:30 a.m. 12-19-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Seat Pleasant P.S. (County) (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Jan 1, 1957	
EXAMINER'S NAME (Type) JAMES I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/4/57		22c. NAME OF CEMETERY OR CREMATORY Wash. Nat.		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS 517-11th St SE Wash, D.C.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

BUREAU V. N.

1957 2 Nov

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00978

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Brentwood			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1 4526 39th Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Haywood Middle Bernard Last Marshall				4. DATE OF DEATH Month January Day 23 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH June 7, 1911		9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Candy and tobacco		11. BIRTHPLACE (State or foreign country) Dist. of Columbia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William A. Marshall				14. MOTHER'S MAIDEN NAME Vera C. Montgomery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W.W.2		16. SOCIAL SECURITY NO.		17. INFORMANT Address Alice Ethel Marshall; same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Cardiovascular renal disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH Sudden </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>John J. Maloney</i> M.D. EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED January 23, 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/24/57		22c. NAME OF CEMETERY OR CREMATORY McGraw Funeral Home			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. McGraw</i>		ADDRESS 1820 9th Ave NW		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <i>Robert E. McGraw</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

JAN 28 1957

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

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Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

0097945

1. PLACE OF DEATH a. COUNTY Prince Georges Riverdale		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D. C. b. COUNTY MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 1/2 hour	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 2025 Eye St., N. W.	
3. NAME OF DECEASED (Type or print) First Victor Middle Mc Nabb Last Mc Nabb		4. DATE OF DEATH Month January Day 14 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Dec 1909
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 14 Days 14 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Unk.	
11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Victor McNabb		14. MOTHER'S MAIDEN NAME MARY A. VESEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Margaret M. McNabb		65 Elm Street Rumford, Rhode Island	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Fractured skull Conditions, if any, which gave rise to immediate cause (b) Fractured skull (c) Fractured skull DUE TO Fractured skull (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured skull			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile collision.	
20c. TIME OF INJURY Month, Day, Year 2.15 PM 1-14-57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Muirkirk Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit		22b. DATE THEREOF Jan 15, 1957	
22c. NAME OF CEMETERY OR CREMATORY T.F. Moanhan & Son Fu. Home		22d. LOCATION (City, town, or county) (State) Providence, Rhode Island	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR Jan 21 1957		24b. REGISTRAR'S SIGNATURE James S. Sweeney	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	

BUREAU T. J.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00980

Reg. Dist. No.

1021

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> c. LENGTH OF STAY IN 1b <u>4 years</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> d. STREET ADDRESS <u>Route # 2, Box 172</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Agnes Pauline Medley</u>				4. DATE OF DEATH Month Day Year <u>January 8 19 57</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1952</u>		9. AGE (In years last birthday) <u>4 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>James Robert Medley</u>						14. MOTHER'S MAIDEN NAME <u>Mary Agnes Williams</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>James Robert Medley, same as # 2</u>				17. INFORMANT Address <u>James Robert Medley, same as # 2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Universal burns of the body, second and third degree</u> DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Occupant of a room that caught on fire</u>											
20c. TIME OF INJURY Month, Day, Year Hour <u>3:30</u> p.m. <u>1/8</u> 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Upper Marlboro</u> (County) <u>Pr. Geo.</u> (State) <u>Md</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type) <u>James I. Boyd</u>						DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>January 9, 1957</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-12-57</u>				22b. DATE THEREOF <u>1-12-57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Holy Family</u>				22d. LOCATION (City, town, or county) <u>Woodman</u> (State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington + Sons. 467 N St NW. Wash DC</u>						ADDRESS <u>467 N St NW. Wash DC</u>						24a. REC'D BY REGISTRAR <u>JAN 14 57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00981

Reg. Dist. No.

1022

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>			c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route # 2, Box 172</u>				d. STREET ADDRESS <u>Route # 2, Box 172</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Pearlline</u> <u>Medley</u>				4. DATE OF DEATH Month Day Year <u>January</u> <u>8</u> <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1952</u>	
9. AGE (In years last birthday) <u>4 yrs.</u>		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY 				11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Robert Medley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Agnes Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. 		17. INFORMANT Address <u>James Robert Medley, Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Universal burns of the body, Second and third degree</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Occupant of a room that caught on fire</u>			
20c. TIME OF INJURY Month, Day, Year Hour Minute P. M. <u>3:30</u> <u>1/8/57</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Upper Marlboro</u> <u>P. G.</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type) <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <u>January 9, 1957</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-12-57</u>			
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Family</u>		22d. LOCATION (City, town, or county) (State) <u>Woodman</u> <u>Md</u>		24a. REC'D BY REGISTRAR <u>20243</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington + Son</u>				ADDRESS <u>467 N. SENE Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00982

Reg. Dist. No.

1023

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 2, Box 172				d. STREET ADDRESS Route # 2, Box 172		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First Middle Last Ida Marie Medley				4. DATE OF DEATH Month Day Year January 8 1957			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1955		9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Robert Medley				14. MOTHER'S MAIDEN NAME Mary Agnes Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address James Robert Medley, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Universal burns of the body, second and third degree DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of a room that caught on fire					
20c. TIME OF INJURY Month, Day, Year Hour 3:30 1/8/57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Upper Marlboro P. G. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 9, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-12-57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Haley Family		22d. LOCATION (City, town, or county) (State) Woodman, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Sons				ADDRESS 467 N St. N.W. Wash. D. C.		24a. REC'D BY REGISTRAR DATE Jan 14 57	
				24b. REGISTRAR'S SIGNATURE W. S. Smith			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARY AND STATE DEPARTMENT OF HEALTH - ESTABLISHED 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 14 1957
BUREAU V. S.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

970

CERTIFICATE OF DEATH

00983

Reg. Dist. No.

739

1. PLACE OF DEATH a. COUNTY <u>Pri Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pri Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>42</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Benice</u> First <u>Miller</u> Last		4. DATE OF DEATH <u>Jan</u> Month <u>12</u> Day <u>1957</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 14 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Howard Co mcl</u>	
13. FATHER'S NAME <u>John Colter</u>		14. MOTHER'S MAIDEN NAME <u>Sofia Gibson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Sara</u> Address <u>Hayes</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive heart disease</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>High blood pressure</u> DUE TO (c) <u>3 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>asthma</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 12, 1957</u> to <u>Dec 12, 1957</u> that I last saw the deceased alive on <u>Dec 12, 1957</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Laurel Md</u> DATE SIGNED <u>Dec 13, 1957</u>			
ACTUAL SIGNATURE <u>W. S. Hopson</u> M.D.		DATE SIGNED <u>Dec 13, 1957</u>	
PHYSICIAN'S NAME (Type) <u>W. S. HOPSON</u>		LAUREL MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 16 1957</u>	<u>Bacon's Chapel</u>	<u>Anne Arnold co mcl</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<u>Ridgely Selby 401 Wash ave</u>		<u>DATE</u>	
<u>Laurel Md</u>		<u>Jan 17 1957</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

971

CERTIFICATE OF DEATH

Reg. Dist. No.

00984

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b 5 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park Md.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 4620 Harvard Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles E. Middle Moore Last Jr.				4. DATE OF DEATH Month Jan Day 25 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-19-1899	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min. 57		IF UNDER 24 HRS. Months 57 Days 57 Hours 57 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer- REA-US Gov't.				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles E. Moore				14. MOTHER'S MAIDEN NAME Gertrude H. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Atlanta Moore			
17. INFORMANT Wife Address Same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Bilateral Hydrothorax (b) Broncho-pneumonia, Bilat DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4 Days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Paralysis, Cause undetermined 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JAN 1, 1957 to JAN 25, 1957 that I last saw the deceased alive on JAN 25, 1957 , and that death occurred at 4:58 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 4713 - Harvard Rd College Park, Md. DATE SIGNED JAN 28 57							
ACTUAL SIGNATURE Dr. Etienne M.D. 4713 - Harvard Rd College Park, Md.							
PHYSICIAN'S NAME (Type) Dr. Etienne							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation							
22b. DATE THEREOF 1/25/1957							
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory							
22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hinesco ADDRESS 2901-14th N.W. D.C.							
24a. REC'D BY REGISTRAR JAN 28 57 24b. REGISTRAR'S SIGNATURE Pat Smith							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00985

972

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville Md</u>		c. LENGTH OF STAY IN 1b <u>27 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eliza</u> Middle <u>Moore</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-76</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>So. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Elijah Harris</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/1/57</u> , 19, to <u>1/15/57</u> , 19, that I last saw the deceased alive on <u>1/15/57</u> , 19, and that death occurred at <u>2:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Elmer J. Jefferson</u> M.D.		ADDRESS (Street, city or town, state) <u>Bladenburg, Md.</u> DATE SIGNED <u>1/16/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1-19-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Acre</u>	22d. LOCATION (City, town, or county) (State) <u>Bladenburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington & Son</u> ADDRESS <u>467 N. St. N. W.</u>		24a. REC'D BY REGISTRAR <u>JAN 21 1957</u> 24b. REGISTRAR'S SIGNATURE <u>W. F. ...</u>	

BUREAU V. S.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00986
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X-7 Forestville</u> d. STREET ADDRESS <u>16263 Ritchie Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> ^{First} <u>Clare</u> ^{Middle} <u>Morton</u> ^{Last} 4. DATE OF DEATH <u>January 8</u> 19 <u>57</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 12, 1874</u> 9. AGE (in years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S. &</u> 13. FATHER'S NAME <u>unknown</u> 14. MOTHER'S MAIDEN NAME <u>unknown</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Mrs Inez Morton, same as #2</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia and exhaustion</u> DUE TO <u>812X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Labar pneumonia</u> DUE TO (c) <u>Cerebral Concussion, fractures of pelvis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian struck by an automobile</u> 20c. TIME OF INJURY Month, Day, Year <u>8</u> <u>0</u> a. m. <u>1-3</u> 19 <u>57</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> 20f. (City or town) <u>Forestville P.S. Inc</u> (County) <u> </u> (State) <u> </u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checkbox"="" checked="" type="checkbox/> and find that death resulted from: Natural causes <input type="/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> 			
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-8-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 22b. DATE THEREOF <u>1/9/57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u> 22d. LOCATION (City, town, or county) <u>Colmar Manor, Md</u> (State) <u> </u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Fraser's Sons Hyattsville, Md</u> ADDRESS <u> </u> 24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 11 57</u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 11 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG209 1-18-57 et

1024

CERTIFICATE OF DEATH

00987

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills		c. LENGTH OF STAY IN 16	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4200-70 th Ave.		d. STREET ADDRESS 4200-70 th Ave.	
3. NAME OF DECEASED (Type or print) First Grace F. Middle Murphy Last		4. DATE OF DEATH Jan. 11 th 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/1882
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Bedford, Mich.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Abram Hamilton		14. MOTHER'S MAIDEN NAME Jane Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO CEREBRAL EMBOLISM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE withold (c) INTERVAL BETWEEN ONSET AND DEATH 2 months 10 years.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV 2, 1956, to 11 Jan, 1957, that I last saw the deceased alive on 10 Jan, 1957, and that death occurred at 10:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas G. Maloney M.D.		DATE SIGNED 11 Jan 57	
PHYSICIAN'S NAME (Type) THOMAS G. MALONEY M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/1957	
22c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY		22d. LOCATION (City, town, or county) Battle Creek, Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Mr. Rainey	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE JAN 14 '57			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00988

Reg. Dist. No.

974

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D. O. A.		3c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr., Geo., Gen., Hosp.				d. STREET ADDRESS 4008 38th., St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ROBERT Last MUSSER				4. DATE OF DEATH Month Jan. Day 3 Year 1957				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 Oct. 1911		
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R. R. Eng.			10b. KIND OF BUSINESS OR INDUSTRY Wash., Terml.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH K. MUSSER				14. MOTHER'S MAIDEN NAME NELLIE SMITH				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 719163112		17. INFORMANT MARGUERITE M. MUSSER		Address Same as # 2 (Wife)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of the basilar artery 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease. DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) JOHN T. MALONEY M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> January 3, 1957				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE P. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE JAN 7 57		
				24b. REGISTRAR'S SIGNATURE DeLoach				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		TIME OF BIRTH [Faint text]	
PLACE OF DEATH [Faint text]		DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF MEDICAL EXAMINER [Faint text]		SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]	
CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]	

BUREAU V. S.

JAN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00989

1025

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor		c. LENGTH OF STAY IN 1b 33 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor		d. NAME OF HOSPITAL (If not in hospital, give street address) 3806 Newark Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		/ d. STREET ADDRESS 3806 Newark Road	
3. NAME OF DECEASED (Type or print) First E. Middle PEARL Last NAGEL		4. DATE OF DEATH Month January Day 11th , Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3rd, 1888
9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Pittsburgh, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Gray		14. MOTHER'S MAIDEN NAME Sarah Bradley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Norma C. Bowen, 3806 Newark Rd. Colmar Man		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Hypertensive Cardio-Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 25 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1956 to Jan. 10th, 1957 , that I last saw the deceased alive on Jan. 10th, 1957 , and that death occurred at 12 Noon , from the causes and on the date stated above. ADDRESS (Street, city or town, state) West Hyattsville, Md. DATE SIGNED Jan. 11/1957 ACTUAL SIGNATURE Leon L. Gallin PHYSICIAN'S NAME (Type) Leon L. Gallin			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/1957	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE JAN 16 1957	
24b. REGISTRAR'S SIGNATURE Rebecca			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 6 1928		ALABAMA		MOBILE		ALABAMA		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
JAN 4 1968		MOBILE		MOBILE		ALABAMA		UNITED STATES		HEART DISEASE		NATURAL		BUSINESSMAN	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF NOTARY	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 4 1968		JAN 4 1968		JAN 4 1968		JAN 4 1968		JAN 4 1968		JAN 4 1968		JAN 4 1968		JAN 4 1968	

BUREAU V. S.

JAN 16 1968

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RELIED BY THE HOSPITAL OR ATTENDING PHYSICIAN.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1026

CERTIFICATE OF DEATH

Reg. Dist. No. 239

00990

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laurel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Laurel</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Sandy Spring Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>J.</u> Last <u>Neighbauer</u>				4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1881</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Episcopal Church, Englewood</u>		11. BIRTHPLACE (State or foreign country) <u>Lincolnshire, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Henry William Neighbauer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Pickling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>MISS. J. Neighbauer</u>		17. INFORMANT Address <u>Spacoma, W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 yr</u> <u>8 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Hypertrophy</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1935</u> to <u>1/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/21</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. P. Warren</u> M.D.				ADDRESS (Street, city or town, state) <u>Laurel Md</u> DATE SIGNED <u>1/24/57</u>			
PHYSICIAN'S NAME (Type) <u>B P WARREN</u>				<u>Laurel Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 27, 1957</u>		<u>St. Philip's Cem.</u>		<u>Laurel Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mc Witt & Carlton</u> ADDRESS <u>Laurel Md</u>				24a. REC'D BY REGISTRAR <u>Jan 30</u>		24b. REGISTRAR'S SIGNATURE <u>M. Bradshaw</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
1957
CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>Robert Warren</i>		2. SEX <i>Male</i>	
3. DATE OF BIRTH <i>10/1/1911</i>		4. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
5. DATE OF DEATH <i>1/3/57</i>		6. PLACE OF DEATH <i>St. Louis, Mo.</i>	
7. TIME OF DEATH <i>10:15 P.M.</i>		8. CAUSE OF DEATH <i>Myocardial Infarction</i>	
9. MANNER OF DEATH <i>Natural</i>		10. SIGNATURE OF PHYSICIAN <i>Dr. J. B. Warren</i>	
11. SIGNATURE OF REGISTRAR <i>J. B. Warren</i>		12. SIGNATURE OF WITNESSES <i>Dr. J. B. Warren</i>	
13. SIGNATURE OF DECEASED <i>Robert Warren</i>		14. SIGNATURE OF NEXT OF KIN <i>Dr. J. B. Warren</i>	
15. SIGNATURE OF BURIAL OFFICIAL <i>Dr. J. B. Warren</i>		16. SIGNATURE OF CHURCH OFFICIAL <i>Dr. J. B. Warren</i>	
17. SIGNATURE OF FUNERAL HOME <i>Dr. J. B. Warren</i>		18. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
19. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		20. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
21. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		22. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
23. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		24. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
25. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		26. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
27. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		28. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
29. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		30. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
31. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		32. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
33. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		34. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
35. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		36. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
37. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		38. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
39. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		40. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
41. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		42. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
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45. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		46. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
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51. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		52. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
53. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		54. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
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59. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		60. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
61. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		62. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
63. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		64. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
65. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		66. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
67. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		68. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
69. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		70. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
71. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		72. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
73. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		74. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
75. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		76. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
77. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		78. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
79. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		80. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
81. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		82. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
83. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		84. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
85. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		86. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
87. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		88. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
89. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		90. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
91. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		92. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
93. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		94. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
95. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		96. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
97. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		98. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	
99. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>		100. SIGNATURE OF OTHER OFFICIAL <i>Dr. J. B. Warren</i>	

RECEIVED
JAN 31 1957
BUREAU V. S.

931

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges'</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges'</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. RAINIER</u>				c. LENGTH OF STAY IN 1b <u>9 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3726 36TH ST.</u>				d. STREET ADDRESS <u>3726 36TH ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>Nelson</u> Last <u>Nelson</u>				4. DATE OF DEATH JAN 29 1957			
5. SEX <u>F</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>OCT 10 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor Int. Revenue.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ST. LOUIS, Missouri</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JAMES P. NELSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY A. BANNON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss Eudora Gardner</u> Address <u>3726 36TH ST MT RAINIER MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> (c) <u>Cerebral Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u> <u>8 years</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> 19 <u>55</u> , to <u>JAN 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JAN 28</u> , 19 <u>57</u> , and that death occurred at <u>130 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat</u> M.D. <u>3503 PERRY ST</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1/29/57</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT</u> <u>MT RAINIER MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home</u> ADDRESS <u>mt. Rainier Md</u>				24a. REC'D BY REGISTRAR <u>JAMES SEEVERS</u>		24b. REGISTRAR'S SIGNATURE <u>JAMES SEEVERS</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA		16. PREVIOUS DRUGS	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED		21. SIGNATURE OF NEXT OF KIN		22. SIGNATURE OF BURIAL OFFICIAL		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF CEMETERY	
25. DATE OF INTERVIEW		26. TIME OF INTERVIEW		27. PLACE OF INTERVIEW		28. NAME OF INTERVIEWER		29. TITLE OF INTERVIEWER		30. ORGANIZATION OF INTERVIEWER		31. ADDRESS OF INTERVIEWER		32. PHONE NUMBER OF INTERVIEWER	

BUREAU V. 3

JAN 30 1957

RECEIVED

975

CERTIFICATE OF DEATH

Reg. Dist. No. 00992

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince /George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine Bell Noack		4. DATE OF DEATH Jan 16 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/70
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Benjamin Ashley Bell		14. MOTHER'S MAIDEN NAME Fannie Powers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Daughter Kathryn Noack Mc Clay		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 24 hrs several yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:40 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Till Bergeman M.D.		ADDRESS (Street, city or town, state) 4319 Gallatin St Hyattsville Md	
PHYSICIAN'S NAME (Type) Till Bergeman		DATE SIGNED M.O	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/19/57	22c. NAME OF CEMETERY OR CREMATORY Aquia Church cemetery	22d. LOCATION (City, town, or county) (State) Stafford County Virginia
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR JAN 21 57	24b. REGISTRAR'S SIGNATURE Overman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 21 1957

RECEIVED

1027

CERTIFICATE OF DEATH

00993

Reg. Dist. No.

142

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Colmar Manor</u>				c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Colmar Manor</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3409-43rd Ave. Colmar Manor</u>				d. STREET ADDRESS <u>13409-43rd Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank A. O'Brien</u>				4. DATE OF DEATH Month Day Year <u>Jan. 24 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/23, 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTH PLACE (State or foreign country) <u>Washington, DC.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Michael O'Brien</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Sullivan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Joseph O'Brien</u>				Address <u>address above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/15</u> , 19 <u>54</u> , to <u>1/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/24</u> , 19 <u>57</u> , and that death occurred at <u>6:45 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Earl W. Graeff</u> M.D. <u>2716 Kerkwood Place</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>EARL W. GRAEFF, M.D.</u> <u>W. Hyattsville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>1/28/57</u>		<u>York Lincoln Colmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				ADDRESS <u>3200-R.I. Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Gannie Campbell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
JAN 30 1957
BUREAU V. S.

NAME (Last, first, middle)		DATE OF BIRTH		PLACE OF BIRTH	
George Washington		1900		Maryland	
RACE		SEX		MARRIAGE	
White		Male		Married	
EDUCATION		OCCUPATION		CAUSE OF DEATH	
High School		Farmer		Heart Disease	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
January 28, 1957		Home		Natural	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
LOCAL HEALTH OFFICER		STATE HEALTH OFFICER		FEDERAL HEALTH OFFICER	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00994

CERTIFICATE OF DEATH

976

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOPPERS MALL 600</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges</u>				d. STREET ADDRESS <u>TOPPERS MALL 600</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Robert</u> Middle <u>OWENS</u> Last <u>OWENS</u>		4. DATE OF DEATH		Month <u>1-14</u> Day <u>1957</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-56</u>		9. AGE (In years last birthday) yrs. <u>2</u> Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Michael Owens</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Elenora ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>mother -</u>		Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema - Cause</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>undetermined</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/1/57</u> , 19 <u>57</u> , to <u>1/14/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/14/57</u> , 19 <u>57</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. A. Holbrook</u> M.D.				ADDRESS (Street, city or town, state) <u>4500 College Ave., College Park, Md.</u>		DATE SIGNED <u>1/18/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Holbrook</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Gen Hosp Chesley Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alvin N. Penn - Jr. Supt</u> ADDRESS _____				24a. REC'D BY REGISTRAR DATE <u>1957</u>		24b. REGISTRAR'S SIGNATURE <u>Alvin N. Penn</u>	

5006313xv2

BUREAU V. S.

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

977

CERTIFICATE OF DEATH

00995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b 14 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 507 73rd. Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Elizabeth Middle H. Last Palmer				4. DATE OF DEATH Month Jan. Day 19 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-17-89	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Unknown				14. MOTHER'S M maiden NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Son Address William D. Palmer Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 331X DUE TO (b) Hypertension, generalized arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Sclerosis. INTERVAL BETWEEN ONSET AND DEATH 3-month							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from December, 1956 to Jan. 19, 1957 , that I last saw the deceased alive on Jan. 18, 1957 , and that death occurred at 855 A. M. from the causes and on the date stated above. Max M. Herzberg ADDRESS (Street, city or town, state) 7016 - Prep St., Seat Pleasant, Md. DATE SIGNED Jan 23 57							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) Dr. Herzberg							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF 1-23-57		22c. NAME OF CEMETERY OR CREMATORY Abingdon Cemetery		22d. LOCATION (City, town, or county) (State) South Boston Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers ADDRESS 517-11th St. S.E.				24a. REC'D BY REGISTRAR DATE Jan 23 57		24b. REGISTRAR'S SIGNATURE W. W. Chambers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00996**

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 3908 53rd Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Deborah Middle Phillips Last 				4. DATE OF DEATH Month January Day 25 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-16-56		9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 YEAR Months 4 Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Phillips				14. MOTHER'S MAIDEN NAME Patricia Vergot			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 		16. SOCIAL SECURITY NO. 		17. INFORMANT Address Father; same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 954X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ether anesthesia DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malignant lymphoma							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Death occurred during ether anesthesia given for biopsy of inguinal and cervical nodes					
20c. TIME OF INJURY Month, Day, Year 1:35 P.M. 1-25-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Cheverly Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> January 25, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/57		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE JAN 30 57		24b. REGISTRAR'S SIGNATURE Overland	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 30 1957

BUREAU V. 3

RECEIVED

JAN 30 1957

RECEIVED

JAN 30 1957

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

979

CERTIFICATE OF DEATH

00997

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 4301 Farragut Street			
3. NAME OF DECEASED (Type or print) First Myles Middle Henry Last Quail Sr.				4. DATE OF DEATH Month Jan Day 18 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 July 1896	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 6 Days 18 Hours 15 Min.		IF UNDER 24 HRS. Months 6 Days 18 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Investments				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Masaachusetts	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Thomas Quail				14. MOTHER'S MAIDEN NAME Mary Maloney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 557 07 5486		17. INFORMANT Address Mary Helen Quail Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Hypertension						INTERVAL BETWEEN ONSET AND DEATH 6 mos 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1953 , to 1-18-57 , that I last saw the deceased alive on 1-18-57 , and that death occurred at 5:45 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leonard Hays M.D. Hyattsville, Md.				DATE SIGNED 1-18-57			
PHYSICIAN'S NAME (Type) Leonard Hays				Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 22, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR JAN 23 '57		24b. REGISTRAR'S SIGNATURE W. H. ...	

MEDICAL CERTIFICATION

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 00998

980

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPER MARLBORO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES' GEN. HOSP.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle FENDELL Last RAWLINGS		4. DATE OF DEATH Month JANUARY Day 15 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 17, 1890
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tenant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edmund Rawlings		14. MOTHER'S MAIDEN NAME Julia Canter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Myrtle Rawlings Address Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of stomach DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) appendicitis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 7, 1957 to Jan 15, 1957 , that I last saw the deceased alive on Jan 15, 1957 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald W. Mitchell M.D.		ADDRESS (Street, city or town, state) 1746 K St., N. W., Washington, D.C. DATE SIGNED Jan 18 '57	
PHYSICIAN'S NAME (Type) Donald W. Mitchell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/17/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR JAN 18 '57	24b. REGISTRAR'S SIGNATURE Qu...

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

18 JAN 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

981

CERTIFICATE OF DEATH

00999

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Pc. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Selend Memorial</u>				d. STREET ADDRESS <u>1 + 914-40th Pl.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lottie</u> Middle <u>Ann</u> Last <u>Readmond</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>4-19-76</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Oliver Van Horn</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Mulligan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>daughter</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <u>12 DAYS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/16, 1956</u> , to <u>JAN 23, 1957</u> , that I last saw the deceased alive on <u>JAN. 23, 1957</u> , and that death occurred at <u>2:57 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C.I. Houmann</u>				M.D. <u>4404 Queensbury Dr. Riverdale, Md.</u>			
PHYSICIAN'S NAME (Type) <u>G.I. HOUMANN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Alexandria, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				24a. REC'D BY REGISTRAR <u>28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James Seares</u>	

RECEIVED

AN 28 1957

BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED JAMES EARL RAY	
2. SEX Male	
3. AGE 35	
4. DATE OF DEATH April 4, 1968	
5. PLACE OF DEATH Memphis, Tennessee	
6. CAUSE OF DEATH Suicide	
7. MANNER OF DEATH Homicide	
8. PLACE OF BIRTH Jackson, Mississippi	
9. DATE OF BIRTH March 22, 1933	
10. SEX OF BIRTH Male	
11. RACE White	
12. RELIGION Methodist	
13. OCCUPATION Attorney	
14. MARITAL STATUS Single	
15. EDUCATION High School	
16. SOCIAL SECURITY NUMBER [Redacted]	
17. SIGNATURE OF DECEASED [Redacted]	
18. SIGNATURE OF WITNESSES [Redacted]	
19. SIGNATURE OF REGISTRAR [Redacted]	
20. SIGNATURE OF CLERK [Redacted]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG211 3-1-57 et

CERTIFICATE OF DEATH

01000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. (If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills, Maryland.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2601 Cheverly Avenue		e. STREET ADDRESS 4615 68th Place,.	
3. NAME OF DECEASED (Type or print) First Hattie Middle Richter Last		4. DATE OF DEATH Month January 25 Day 19 Year 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1872 ?
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Turn Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Ethel McLean Landover Hills Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X CEREBRO VASCULAR ACCIDENT DUE TO (b) CEREBRAL ATHEROSCLEROSIS DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 24 hr 59M
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 1956, to 25 JAN, 1957, that I last saw the deceased alive on 24 Jan, 1957, and that death occurred at 7:10 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John K ehoe		ADDRESS (Street, city or town, state) 3404 Cheverly Ave Cheverly, Md	
PHYSICIAN'S NAME (Type) John Kehoe		DATE SIGNED 1/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/57	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE 30 57	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF DECEASED	

13. NAME OF PHYSICIAN		14. NAME OF SURGEON		15. NAME OF PATHOLOGIST	
16. NAME OF CORONER		17. NAME OF JURY		18. NAME OF JUDGE	
19. NAME OF WITNESS		20. NAME OF WITNESS		21. NAME OF WITNESS	
22. NAME OF WITNESS		23. NAME OF WITNESS		24. NAME OF WITNESS	

25. NAME OF WITNESS		26. NAME OF WITNESS		27. NAME OF WITNESS	
28. NAME OF WITNESS		29. NAME OF WITNESS		30. NAME OF WITNESS	
31. NAME OF WITNESS		32. NAME OF WITNESS		33. NAME OF WITNESS	
34. NAME OF WITNESS		35. NAME OF WITNESS		36. NAME OF WITNESS	

37. NAME OF WITNESS		38. NAME OF WITNESS		39. NAME OF WITNESS	
40. NAME OF WITNESS		41. NAME OF WITNESS		42. NAME OF WITNESS	
43. NAME OF WITNESS		44. NAME OF WITNESS		45. NAME OF WITNESS	
46. NAME OF WITNESS		47. NAME OF WITNESS		48. NAME OF WITNESS	

BUREAU V. S.

JAN 30 1957

RECEIVED

TO TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1028

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>			
c. LENGTH OF STAY IN 1b <u>4 years</u>				d. STREET ADDRESS <u>15415-Pine St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LUDWIG WILLIAM RICHTER</u>				4. DATE OF DEATH <u>JAN 13</u> 19 <u>57</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 28 1892</u>	
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Valet Shop Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wash Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>EMIL Richter</u>				14. MOTHER'S MAIDEN NAME <u>CHRISTINA MUELLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Maria H Richter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE FAILURE</u> DUE TO <u>MULTIPLE METASTASES ABDOMEN</u> (b) <u>CARCINOMA OF LUNG</u> DUE TO <u>163 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>6 MONTHS</u> <u>2 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>DEC 1951</u> to <u>JAN 13, 1957</u> , that I last saw the deceased alive on <u>JAN 13, 1957</u> , and that death occurred at <u>4:29</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney W. Lowrey</u>				DATE SIGNED <u>JAN 13, 1957</u>			
PHYSICIAN'S NAME (Type) <u>SIDNEY W. LOWREY, M.D.</u>				ADDRESS (Street, city or town, state) <u>7200 Marlboro Rd SE, DISTRICT HEIGHTS, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>COLUMBIA MANOR, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lees, Sr.</u>				ADDRESS <u>300 N. F. D.C.</u>		24a. REC'D BY REGISTRAR <u>Carrie Campbell</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>1-14-57</u>			

BUREAU V. S.

JAN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG211 3-1-57 et

CERTIFICATE OF DEATH

01002

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>PRINCE GEORGES</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry 3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D. C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges Hospital</i>		d. STREET ADDRESS <i>2927 York Pl.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>CATHERINE</i> Last <i>RIDDLE</i>		4. DATE OF DEATH Month <i>1</i> Day <i>5</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 14 1884</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>? Gates</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Margaret Cavileer</i>		Address <i>9101 Antoville Drive College Park, Maryland.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute choleystitis</i> <i>585X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept. 1-5, 1957</i> to <i>1-5, 1957</i> , that I last saw the deceased alive on <i>1-5, 1957</i> , and that death occurred at <i>8:20 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R.D. Bauer</i>		ADDRESS (Street, city or town, state) <i>2513 Buck Lodge Rd. Adelphi, Md.</i>	
PHYSICIAN'S NAME (Type) <i>R.D. BAUER MD</i>		DATE SIGNED <i>1-5-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/8/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Maryland.</i>	
24a. REC'D BY REGISTRAR <i>Jan 8 57</i>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

BUREAU V. S.

JAN 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01003
Reg. Dist. No. 730

1029

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville c. LENGTH OF STAY IN 1b 23 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bowie-Banesville Association property		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt d. STREET ADDRESS 2 J. Eastway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wilbur Middle Orville Last Rock		4. DATE OF DEATH Month January Day 5 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1909
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 4 Days 7 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Meat	11. BIRTHPLACE (State or foreign country) Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Roy Robert Rock	
14. MOTHER'S MAIDEN NAME Melvina Shappy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 579-01-4941		17. INFORMANT Margaret Alice Rock; same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Gunshot wound of head Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound of head	
20c. TIME OF INJURY Month, Day, Year 1- 1957 Hour a. m. 1 p. m. 1		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> out-house	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Beltsville, Pr. Geo.		20f. (City or town) (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED January 5, 1956	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 1-7-57	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home		24a. REC'D BY REGISTRAR John Smith	
ADDRESS 3200-R.I. Ave. Mt. Rainier, Md.		24b. REGISTRAR'S SIGNATURE John Smith	
DATE JAN 8 1957			

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BUREAU V. 8

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JAN 8 1957

RECEIVED

John T. H. H. H.

CERTIFICATE OF DEATH

Reg. Dist. No.

01004

1030

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston Md.				c. LENGTH OF STAY IN 1b 50 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4914 49th avenue,.				d. STREET ADDRESS 4914 49th avenue,.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Margaret M. Salzman				4. DATE OF DEATH Jan 22, 1957-19			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 19, 1874	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT uth Middleton Edmonston, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.U.A. - Rt. Hemiparesis 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular heart & big artery disease DUE TO (c) Hypertension - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 15 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 3, 1942 to 1-22, 1957, that I last saw the deceased alive on 1-22, 1957, and that death occurred at 10:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George H. Haggard M.D. 3712-38th Ave. Hyattsville, Md. 1-25-57							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE JAN 28 '57	
				24b. REGISTRAR'S SIGNATURE R. H. Haggard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1031

CERTIFICATE OF DEATH

01005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRADBURY HEIGHTS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRADBURY HEIGHTS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4908 S ST</u>		d. STREET ADDRESS <u>14908 S ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>FRANCIS</u> Middle <u>SAULSBURY</u> Last		4. DATE OF DEATH <u>JAN</u> Month <u>2</u> Day <u>1957</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 19, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CITY WATER DEPT.</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES SAULSBURY</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET PHILLIPS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MISS NORA SAULSBURY</u> Address <u>4908 S ST</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>5 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>54</u> , to <u>Jan 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 31</u> , 19 <u>56</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2210 Meade Ave SE</u> DATE SIGNED <u>1-2-57</u> ACTUAL SIGNATURE <u>John B Fegan</u> M.D. <u>Wash D.C.</u> PHYSICIAN'S NAME (Type) <u>JOHN B FEGAN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 5, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE</u>		22d. LOCATION (City, town, or county) (State) <u>DELAWARE OHIO</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>JAN 4 '57</u> 24b. REGISTRAR'S SIGNATURE <u>W.W. Chambers</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE		3. RACE WHITE		4. DATE OF BIRTH 1892-03-15		5. PLACE OF BIRTH NEW YORK	
6. DATE OF DEATH 1957-01-04		7. PLACE OF DEATH HOME		8. CAUSE OF DEATH HEART DISEASE		9. MANNER OF DEATH NATURAL		10. SIGNATURE OF PHYSICIAN [Signature]	
11. SIGNATURE OF REGISTRAR [Signature]		12. SIGNATURE OF CLERK [Signature]		13. SIGNATURE OF WITNESS [Signature]		14. SIGNATURE OF WITNESS [Signature]		15. SIGNATURE OF WITNESS [Signature]	
16. SIGNATURE OF WITNESS [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF WITNESS [Signature]		19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF WITNESS [Signature]	
21. SIGNATURE OF WITNESS [Signature]		22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF WITNESS [Signature]		24. SIGNATURE OF WITNESS [Signature]		25. SIGNATURE OF WITNESS [Signature]	
26. SIGNATURE OF WITNESS [Signature]		27. SIGNATURE OF WITNESS [Signature]		28. SIGNATURE OF WITNESS [Signature]		29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF WITNESS [Signature]	
31. SIGNATURE OF WITNESS [Signature]		32. SIGNATURE OF WITNESS [Signature]		33. SIGNATURE OF WITNESS [Signature]		34. SIGNATURE OF WITNESS [Signature]		35. SIGNATURE OF WITNESS [Signature]	
36. SIGNATURE OF WITNESS [Signature]		37. SIGNATURE OF WITNESS [Signature]		38. SIGNATURE OF WITNESS [Signature]		39. SIGNATURE OF WITNESS [Signature]		40. SIGNATURE OF WITNESS [Signature]	
41. SIGNATURE OF WITNESS [Signature]		42. SIGNATURE OF WITNESS [Signature]		43. SIGNATURE OF WITNESS [Signature]		44. SIGNATURE OF WITNESS [Signature]		45. SIGNATURE OF WITNESS [Signature]	
46. SIGNATURE OF WITNESS [Signature]		47. SIGNATURE OF WITNESS [Signature]		48. SIGNATURE OF WITNESS [Signature]		49. SIGNATURE OF WITNESS [Signature]		50. SIGNATURE OF WITNESS [Signature]	
51. SIGNATURE OF WITNESS [Signature]		52. SIGNATURE OF WITNESS [Signature]		53. SIGNATURE OF WITNESS [Signature]		54. SIGNATURE OF WITNESS [Signature]		55. SIGNATURE OF WITNESS [Signature]	
56. SIGNATURE OF WITNESS [Signature]		57. SIGNATURE OF WITNESS [Signature]		58. SIGNATURE OF WITNESS [Signature]		59. SIGNATURE OF WITNESS [Signature]		60. SIGNATURE OF WITNESS [Signature]	
61. SIGNATURE OF WITNESS [Signature]		62. SIGNATURE OF WITNESS [Signature]		63. SIGNATURE OF WITNESS [Signature]		64. SIGNATURE OF WITNESS [Signature]		65. SIGNATURE OF WITNESS [Signature]	
66. SIGNATURE OF WITNESS [Signature]		67. SIGNATURE OF WITNESS [Signature]		68. SIGNATURE OF WITNESS [Signature]		69. SIGNATURE OF WITNESS [Signature]		70. SIGNATURE OF WITNESS [Signature]	
71. SIGNATURE OF WITNESS [Signature]		72. SIGNATURE OF WITNESS [Signature]		73. SIGNATURE OF WITNESS [Signature]		74. SIGNATURE OF WITNESS [Signature]		75. SIGNATURE OF WITNESS [Signature]	
76. SIGNATURE OF WITNESS [Signature]		77. SIGNATURE OF WITNESS [Signature]		78. SIGNATURE OF WITNESS [Signature]		79. SIGNATURE OF WITNESS [Signature]		80. SIGNATURE OF WITNESS [Signature]	
81. SIGNATURE OF WITNESS [Signature]		82. SIGNATURE OF WITNESS [Signature]		83. SIGNATURE OF WITNESS [Signature]		84. SIGNATURE OF WITNESS [Signature]		85. SIGNATURE OF WITNESS [Signature]	
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91. SIGNATURE OF WITNESS [Signature]		92. SIGNATURE OF WITNESS [Signature]		93. SIGNATURE OF WITNESS [Signature]		94. SIGNATURE OF WITNESS [Signature]		95. SIGNATURE OF WITNESS [Signature]	
96. SIGNATURE OF WITNESS [Signature]		97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF WITNESS [Signature]		99. SIGNATURE OF WITNESS [Signature]		100. SIGNATURE OF WITNESS [Signature]	

BUREAU V. 8

JAN 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01006

1032

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7119 Tucker Road</u>		d. STREET ADDRESS <u>7119 Tucker Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Island Marvin Savoy</u>		4. DATE OF DEATH <u>January 26 19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4, 1956</u>
9. AGE (In years last birthday) <u>7 yrs.</u>		IF UNDER 1 YEAR <u>7</u> Months <u>22</u> Days <u>22</u> Hours <u>22</u> Min. <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Elwood Savoy</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Barbara Proctor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>06-12-12345</u>	
17. INFORMANT <u>PAUL ELWOOD SAVOY</u>		Address <u>Oxon Hill, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (b) <u>491X</u> (c), stating the underlying cause lost. (c) <u>491X</u> DUE TO <u>491X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>10</u> a. m. <u>10</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>Jan 26-57</u>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-26-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Ignace Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Oxon Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James I. Boyd</u>		ADDRESS <u>Wheaton Md</u>	
24a. REC'D BY REGISTRAR <u>JAN 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

2077244XV3

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JAN 29 1957

RECEIVED

1033

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2101 Ingraham St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LAURA CAROLINE SCHNEIDER				4. DATE OF DEATH Month Day Year Jan 10 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 Jan 1880	
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ill.	
13. FATHER'S NAME William M. Glen				14. MOTHER'S MAIDEN NAME Mary Leigh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.		17. INFORMANT Ardell Cox. Add. same as #2 Daughter			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Advanced Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Belleville				20g. (County) Ill.		20h. (State) Ill.	
21. I certify that I attended the deceased from 9/6 , 19 56 , to 1/10 , 19 57 , that I last saw the deceased alive on 1/10 , 19 57 , and that death occurred at 4:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1840 Michigan Ave N.E. D.C. DATE SIGNED 1/11/57							
ACTUAL SIGNATURE Frank M. Troggo, Jr.				PHYSICIAN'S NAME (Type) FRANK M. TROGGO, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit-Burial		22b. DATE THEREOF 1/14/57		22c. NAME OF CEMETERY OR CREMATORY Walnut Hill Cemetery		22d. LOCATION (City, town, or county) (State) Belleville Ill.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. RECEIVED BY REGISTRAR 1/11/57	
24b. REGISTRAR'S SIGNATURE W. K. Smith				DATE 1/11/57			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1034

CERTIFICATE OF DEATH

Reg. Dist. No.

01008

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)		c. LENGTH OF STAY IN 1b 2 yrs. 3 mo's	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x3 Washington	
3. NAME OF DECEASED (Type or print) First LAKE Middle STEWART Last		d. STREET ADDRESS 1114 Florida Ave., N.E.	
4. DATE OF DEATH Month JANUARY Day 10 Year 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/15
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, Dept. of San.		10b. KIND OF BUSINESS OR INDUSTRY D.C. Govt.	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Uress Stewart		14. MOTHER'S MAIDEN NAME Mattie Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 002X PULMONARY HEMORRHAGE DUE TO PULMONARY TUBERCULOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RIGHT BRONCHOPLEURAL FISTULA AND TUBERCULOUS EMPYEMA			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/6, 1957, to 1/10, 1957, that I last saw the deceased alive on 1/10, 1957, and that death occurred at 6 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel Leo Finucane M.D.		ADDRESS (Street, city or town, state) Glenn Dale Hospital Glenn Dale, Md.	
DATE SIGNED 1/10/57			
PHYSICIAN'S NAME (Type) Daniel Leo Finucane M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/11/57	
22c. NAME OF CEMETERY OR CREMATORY L.E. Murray & Son 1337-10 St. N.W.		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE L.E. Murray & Son		24a. REC'D BY REGISTRAR DATE 1/10/57	
24b. REGISTRAR'S SIGNATURE W. W. W.			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		Male		35		White		1922		Memphis, Tenn.		April 4, 1968		Nashville, Tenn.		Shot		Suicide		[Signature]		[Signature]	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Attorney		High School		Methodist		Married		None		None		None		None		None		None		None		None	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JAN 18 1957

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE. IT IS THE POLICY OF THE DEPARTMENT TO MAINTAIN THE ACCURACY OF THIS CERTIFICATE AND TO PROVIDE A COPY TO THE FAMILY OF THE DECEASED. IT IS THE POLICY OF THE DEPARTMENT TO MAINTAIN THE ACCURACY OF THIS CERTIFICATE AND TO PROVIDE A COPY TO THE FAMILY OF THE DECEASED.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 245

01009

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5701 Riverdale, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Karlis Straume</u>		4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-5-99</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>2 Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Karlis Straume</u>		14. MOTHER'S MAIDEN NAME <u>Marija Stokmanis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Records</u>		Address <u>4408 Queensberry Rd. Riverdale, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cerebral Hemorrhage</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>54 yrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 25, 1957</u> to <u>Jan 29, 1957</u> , that I last saw the deceased alive on <u>Jan 29, 1957</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. W. Malin</u>		M.D. <u>Riverdale, Md</u>	
PHYSICIAN'S NAME (Type) <u>L. W. Malin, M.D.</u>		DATE SIGNED <u>1-29-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb. 2, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS</u>		ADDRESS <u>Riverdale, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Feb 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>	

FEB 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1035

Reg. Dist. No.

01010

242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. LENGTH OF STAY IN 1b 41 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cipriano Road				d. STREET ADDRESS Cipriano Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roland Middle Charles Last Suesen				4. DATE OF DEATH Month January Day 15 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-15		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months 41 Days 15 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Suesen				14. MOTHER'S MAIDEN NAME Alfreda Winters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 214-14-8794		17. INFORMANT Address Mildred Louise Suesen: 11149 Vier's			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Mill Road, Wheaton, Md.							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock							
976X DUE TO Shotgun wound of head							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted wound of head.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. Jan. 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Lanham Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> January 15, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/18/57		22c. NAME OF CEMETERY OR CREMATORY St. Georges Cemetery		22d. LOCATION (City, town, or county) (State) Glendale, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE 21 1957			
				24b. REGISTRAR'S SIGNATURE Carrie Campbell			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John J. Jones		Male		35		White		Jan. 1, 1957		Home	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Previous Illnesses	
Shot in front of head		Suicide		Teacher		High School		Married		None	
Detailed Description of Injury		Toxicology		Alcohol		Drugs		Mental		Physical	
Shot in front of head		None		None		None		None		None	
Signature of Examiner		Signature of Coroner		Signature of Physician		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	

RECEIVED
JAN. 21. 1957
BUREAU V. 5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01011

985

1. PLACE OF DEATH a. COUNTY <u>Prince George County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>83x-3 Arlington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2601 Cherry Avenue</u>				d. STREET ADDRESS <u>4231 S. 36th. Street</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JOSEPHINE</u> Last <u>SULLIVAN</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 25, 1881</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Massenuth</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>Laure, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Champion</u>				14. MOTHER'S MAIDEN NAME <u>Catherine O'Leary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-14-2007</u>		17. INFORMANT Address <u>Mrs. Eleanor A. Tarczynski, same as #2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA.</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF RECTUM</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>OCT 1, 1956</u> , to <u>1/21, 1957</u> , that I last saw the deceased alive on <u>1/20, 1957</u> , and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Kehoe</u>				ADDRESS (Street, city or town, state) <u>3404 CHEVERLY AVE</u>			
PHYSICIAN'S NAME (Type) <u>JOHN KEHOE</u>				DATE SIGNED <u>1/21/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit Burial</u>		22b. DATE THEREOF <u>Jan 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laure, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				ADDRESS <u>254 Carroll St NW DC</u>		24a. REC'D BY REGISTRAR <u>W. H. Houch</u>	
				DATE <u>JAN 23 57</u>		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

JAN 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

986

CERTIFICATE OF DEATH

Reg. Dist. No.

01012

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Gen Hospital				d. STREET ADDRESS 2420 University Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Joseph Middle Sunderland Last Sunderland				4. DATE OF DEATH Month Jan. Day 2 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20, 1919	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months 37		IF UNDER 24 HRS. Days 37 Hours 37 Min. 37			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Benjamin Sunderland				14. MOTHER'S MAIDEN NAME Ellen Donlan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W W 11				16. SOCIAL SECURITY NO.			
17. INFORMANT Marie Sheffer Address 2538 E York Street, Philadelphia, Pa.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Glom a hemorrhage 193x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 wks. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12-21-1956 , to 12-31-1956 , that I last saw the deceased alive on 1/1/1957 , and that death occurred at 12,35A AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE [Signature] M.D.							
PHYSICIAN'S NAME (Type) F. E. MUSEY, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F; Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR 7 57 DATE		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

1957 2 Nov

RECEIVED

1036

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>20 yrs x 2 Cedar Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hattie I. Sutton</u>		4. DATE OF DEATH <u>JAN 1 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 15, 1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>medical</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Johns</u>		14. MOTHER'S MAIDEN NAME <u>Susie Blake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u> - 17. INFORMANT <u>James T. Sutton</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> 332x DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Arteriosclerosis</u> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>20 months</u> <u>7</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 10</u> , 19 <u>57</u> , to <u>JAN 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JAN 1</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Nelson</u>		ADDRESS (Street, city or town, state) <u>4112 GRANT ST. N.E. WASH DC 11157</u> DATE SIGNED <u>1/1/57</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Nelson</u>		<u>4112 GRANT ST. N.E.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-4-57</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Sutherland Rd Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L. Washington</u> ADDRESS <u>467 N. St. N.W.</u>		24a. REC'D BY REGISTRAR <u>U. H. Hedrick</u> 24b. REGISTRAR'S SIGNATURE <u>U. H. Hedrick</u>	

CERTIFICATE OF DEATH

REG. NO. 111

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>		5. PLACE OF BIRTH <i>John Doe, Md.</i>	
6. DATE OF DEATH <i>Jan 1, 1957</i>		7. TIME OF DEATH <i>10:00 AM</i>		8. PLACE OF DEATH <i>John Doe, Md.</i>		9. CAUSE OF DEATH <i>Heart Disease</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF DECEASED <i>John Doe</i>		12. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		13. SIGNATURE OF PHYSICIAN <i>John Doe</i>		14. SIGNATURE OF CORONER <i>John Doe</i>		15. SIGNATURE OF JURY <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>		19. SIGNATURE OF CORONER <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		23. SIGNATURE OF PHYSICIAN <i>John Doe</i>		24. SIGNATURE OF CORONER <i>John Doe</i>		25. SIGNATURE OF JURY <i>John Doe</i>	
26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		28. SIGNATURE OF PHYSICIAN <i>John Doe</i>		29. SIGNATURE OF CORONER <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		33. SIGNATURE OF PHYSICIAN <i>John Doe</i>		34. SIGNATURE OF CORONER <i>John Doe</i>		35. SIGNATURE OF JURY <i>John Doe</i>	
36. SIGNATURE OF DECEASED <i>John Doe</i>		37. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		38. SIGNATURE OF PHYSICIAN <i>John Doe</i>		39. SIGNATURE OF CORONER <i>John Doe</i>		40. SIGNATURE OF JURY <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		43. SIGNATURE OF PHYSICIAN <i>John Doe</i>		44. SIGNATURE OF CORONER <i>John Doe</i>		45. SIGNATURE OF JURY <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		48. SIGNATURE OF PHYSICIAN <i>John Doe</i>		49. SIGNATURE OF CORONER <i>John Doe</i>		50. SIGNATURE OF JURY <i>John Doe</i>	
51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		53. SIGNATURE OF PHYSICIAN <i>John Doe</i>		54. SIGNATURE OF CORONER <i>John Doe</i>		55. SIGNATURE OF JURY <i>John Doe</i>	
56. SIGNATURE OF DECEASED <i>John Doe</i>		57. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		58. SIGNATURE OF PHYSICIAN <i>John Doe</i>		59. SIGNATURE OF CORONER <i>John Doe</i>		60. SIGNATURE OF JURY <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		63. SIGNATURE OF PHYSICIAN <i>John Doe</i>		64. SIGNATURE OF CORONER <i>John Doe</i>		65. SIGNATURE OF JURY <i>John Doe</i>	
66. SIGNATURE OF DECEASED <i>John Doe</i>		67. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		68. SIGNATURE OF PHYSICIAN <i>John Doe</i>		69. SIGNATURE OF CORONER <i>John Doe</i>		70. SIGNATURE OF JURY <i>John Doe</i>	
71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		73. SIGNATURE OF PHYSICIAN <i>John Doe</i>		74. SIGNATURE OF CORONER <i>John Doe</i>		75. SIGNATURE OF JURY <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		78. SIGNATURE OF PHYSICIAN <i>John Doe</i>		79. SIGNATURE OF CORONER <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		83. SIGNATURE OF PHYSICIAN <i>John Doe</i>		84. SIGNATURE OF CORONER <i>John Doe</i>		85. SIGNATURE OF JURY <i>John Doe</i>	
86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		88. SIGNATURE OF PHYSICIAN <i>John Doe</i>		89. SIGNATURE OF CORONER <i>John Doe</i>		90. SIGNATURE OF JURY <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		93. SIGNATURE OF PHYSICIAN <i>John Doe</i>		94. SIGNATURE OF CORONER <i>John Doe</i>		95. SIGNATURE OF JURY <i>John Doe</i>	
96. SIGNATURE OF DECEASED <i>John Doe</i>		97. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		98. SIGNATURE OF PHYSICIAN <i>John Doe</i>		99. SIGNATURE OF CORONER <i>John Doe</i>		100. SIGNATURE OF JURY <i>John Doe</i>	

BUREAU V. 3

JAN 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G210, 2/4/57 bn
CERTIFICATE OF DEATH

987

01014

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				e. STREET ADDRESS 4913 - 42nd. Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Wilton Last Taliaferro				4. DATE OF DEATH Month January Day 16 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21, 1913	
9. AGE (In years last birthday) 44 3/4 yrs.		IF UNDER 1 YEAR Months 3 Days 16 Hours 19 Min.		IF UNDER 24 HRS. Months 3 Days 16 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10b. KIND OF BUSINESS OR INDUSTRY Arcade Barber Shop			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Lawrence E. Taliaferro				14. MOTHER'S MAIDEN NAME Bertie Ellen Madison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?		17. INFORMANT Hospital Record			
				Address 4408 Queensbury Rd., Riverdale			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multistate Carcinoma 199.9 DUE TO primary site undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 months (c) 6 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 11:45							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 26 , 19 56 , to Jan. 16 , 19 57 , that I last saw the deceased alive on 19 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE L. W. Malin ADDRESS (Street, city or town, state) Riverdale, Md. DATE SIGNED Jan 16, 1957							
PHYSICIAN'S NAME (Type) L. W. Malin, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/19/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Deasch's Sons ADDRESS 4739 - Ball. Ave. Hyattsville, Md.							
24a. REC'D BY REGISTRAR DATE 21 1957							
24b. REGISTRAR'S SIGNATURE James Seese							

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

988

CERTIFICATE OF DEATH

01015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 10 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. STREET ADDRESS 2421 70th Street							
3. NAME OF DECEASED (Type or print) First Sara Middle Elizabeth Last Taylor				4. DATE OF DEATH Month Jan Day 30 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 - 20 - 1877	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79		IF UNDER 24 HRS. Months 79 Days 79 Hours 79 Min. 79			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George E. West				14. MOTHER'S MAIDEN NAME Unknown Madison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Bernard E. Taylor, 421 70th St. Seat Pleasant Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. (clinic) DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 day DUE TO (c) 1 day PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 day							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 30, 1957 to Jan 30, 1957 that I last saw the deceased alive on Jan 30, 1957 , and that death occurred at 6:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3717-38th Ave DATE SIGNED 1-31-57							
ACTUAL SIGNATURE George J. Hageage M.D.							
PHYSICIAN'S NAME (Type) GEORGE J. HAGEAGE, M.D.				3717 38th Avenue, Cottage City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY		22d. LOCATION (City, town, or county) (State)	
Burial		Feb. 2, 1957		Fort Lincoln Cemetery		Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS, Riverdale, Maryland.				24a. REC'D BY REGISTRAR FEB 4 '57		24b. REGISTRAR'S SIGNATURE W. W. Chambers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

288

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		65		JAN 15 1892	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD.		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
FEB 3 1957		BALTIMORE, MD.		10:00 AM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
FEB 3 1957		FEB 3 1957		FEB 3 1957		FEB 3 1957	

BURIAL V. S.

FEB 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

01016

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince Georges, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4012-35th Street		d. STREET ADDRESS 4012-35th Street	
3. NAME OF DECEASED (Type or print) Nettie First Middle Last		4. DATE OF DEATH Jan 23 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk - Ret.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Mark Thomas		14. MOTHER'S MAIDEN NAME Anna Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Frances C. Bates		Address address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175X Carcinoma of ovary with metastases DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 34, 1954, to Jan 10, 1957, that I last saw the deceased alive on Jan 10, 1957, and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leonk Gallin		DATE SIGNED Jan 23 1957	
PHYSICIAN'S NAME (Type) University Hills Md.		ADDRESS (Street, city or town, state) 7206 Cotterville Rd	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/57	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hall's Funeral Home, Inc.		ADDRESS Mt. Rainier, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE James Severey	
DATE JAN 28 1957			

RECEIVED

JAN 28 1957

BUREAU V. 2

MAKLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
MARRIAGE: [illegible]
OCCUPATION: [illegible]
EDUCATION: [illegible]
RELIGION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF DECEASED: [illegible]
SIGNATURE OF WITNESS: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF CORONER: [illegible]
SIGNATURE OF JUDGE: [illegible]
SIGNATURE OF CLERK: [illegible]
SIGNATURE OF [illegible]: [illegible]

THE DEPARTMENT OF HEALTH, BUREAU OF VITAL RECORDS, is authorized to receive and record all deaths occurring in this State, and to issue certificates of death therefor. The information furnished on this certificate is for the purpose of recording and indexing only, and is not to be used for any other purpose. The information furnished on this certificate is for the purpose of recording and indexing only, and is not to be used for any other purpose.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

989

CERTIFICATE OF DEATH

Reg. Dist. No. 01017

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 8 hr. 5 m.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Co. Gen. Hospital				d. STREET ADDRESS Box 202			
3. NAME OF DECEASED (Type or print) Baby Boy Tolley				4. DATE OF DEATH 1-4-57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-4-57	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Tolley				14. MOTHER'S MAIDEN NAME Frances Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT mother (Frances C. Tolley)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 Cardiac - Respiratory Failure DUE TO (b) Atherosclerosis and Hypertension DUE TO (c) lying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 4, 1957, to Jan 4, 1957, that I last saw the deceased alive on Jan 4, 1957, and that death occurred at 4:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William F. Schmitz M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Jan. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Belview Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Ceanberry, Avery Co, N. C.	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS Laurel, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 9 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 11, 13, 14, Film G211 2-25-57 et

01018

990

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 No. Brentwood		d. STREET ADDRESS 4510 40th Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosa Middle B Last Tyler		4. DATE OF DEATH Month Jan Day 12 Year 1957	
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lynchburg, Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Johnson		14. MOTHER'S MAIDEN NAME Harriet (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **1/1**, 19**57**, to **1/12**, 19**57**, that I last saw the deceased alive on **1/4**, 19**57**, and that death occurred at **4, 10 A.M.**, from the causes and on the date stated above.

ACTUAL SIGNATURE **Julius J. [Signature]** M.D. ADDRESS (Street, city or town, state) **Baltimore, Md.** DATE SIGNED **1/12/57**

PHYSICIAN'S NAME (Type) **Julius J. [Signature]**

22a. BURIAL, CREMATION, REMOVAL (Specify) 1-45557	22b. DATE THEREOF 1-12-57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) 4600 York Road, Baltimore, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle K. Rollins		24a. REC'D BY REGISTRAR Jan 16 1957	24b. REGISTRAR'S SIGNATURE

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the delay in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01019

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1/2 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRank Middle Joseph Last Villari		4. DATE OF DEATH Month January 22, Day 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1907
9. AGE (In years last birthday) 49 yrs.		10. UNDER 1 YEAR Months 49 Days 0 Hours 0 Min. 0	11. UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Villarl		14. MOTHER'S MAIDEN NAME Jennie Leonardo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Jennie Cain:1720 28th Place S.E. Wash. D.C.	
17. INFORMANT Jennie Cain:1720 28th Place S.E. Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute congestive heart failure (c) Wet brain DUE TO (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cirrhosis of liver			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED January 22, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER ✓	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25 N-7	
22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasche Sons Hyattsville, Md		24. REC'D BY REGISTRAR DATE JAN 28 '57	
24b. REGISTRAR'S SIGNATURE Overseer			

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Frank Villari		Male		39		Oct. 20, 1907	
Place of Birth		Place of Death		Cause of Death		Manner of Death	
Franklin, Indiana		Washington, D.C.		Diphtheria		Natural	
Residence		Place of Burial		Name of Physician		Signature of Physician	
Washington, D.C.		Washington, D.C.		J. Edgar Hoover		J. Edgar Hoover	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Clerk	
J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover	

Diagnosis of liver
acute connective tissue disease
not brain

BUREAU V. B.

JAN 28 1957

RECEIVED

992

CERTIFICATE OF DEATH

01020

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE N. J. b. COUNTY Atlantic County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b 20 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEO. GEN. HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 67X-3 VENTNOR	
3. NAME OF DECEASED (Type or print) First Middle Last LOURAINIA VANDEGRIFT Vrooman		4. DATE OF DEATH Month Day Year JAN 25 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-1895
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRED VANDEGRIFT		14. MOTHER'S MAIDEN NAME HARRIET HARVEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT DAUGHTER, LOURAINIA V. BAKER		Address APDELPHI MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED METASTATIC CARCINOMA 175X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA (ADENOC) OF OVARIES DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 MO. 3 MO.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-5 , 1957, to 1-25 , 1957, that I last saw the deceased alive on 1-25 , 1957, and that death occurred at 3:58 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R.D. Baker		ADDRESS (Street, city or town, state) 2513 BULKLEGE RD. DATE SIGNED 1-25-57	
PHYSICIAN'S NAME (Type) R.D. BAKER, M.D.		Address APDELPHI MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Interment 1/25/57	22c. NAME OF CEMETERY OR CREMATORY Philadelphia	22d. LOCATION (City, town, or county) (State) Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE 24b. REGISTRAR'S SIGNATURE Paul Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

937

FILED MAY 1957

1. NAME OF DECEASED W. J. WILSON		2. SEX MALE		3. AGE 72	
4. DATE OF DEATH MAY 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. PLACE OF BIRTH NEW YORK	
10. OCCUPATION RETIRED		11. EDUCATION HIGH SCHOOL		12. RELIGION METHODIST	
13. MARITAL STATUS MARRIED		14. DATE OF MARRIAGE 1915		15. NAME OF SPOUSE MRS. J. WILSON	
16. NAME OF PHYSICIAN DR. J. WILSON		17. NAME OF HOSPITAL ST. JOSEPH'S		18. NAME OF NURSE MRS. J. WILSON	
19. NAME OF FUNERAL HOME WILSON & SONS		20. NAME OF BURIAL PLACE GREENWICH CEMETERY		21. NAME OF MINISTER DR. J. WILSON	
22. NAME OF INTERVIEWER DR. J. WILSON		23. DATE OF INTERVIEW MAY 1957		24. SIGNATURE OF DECEASED W. J. WILSON	
25. SIGNATURE OF WITNESS W. J. WILSON		26. SIGNATURE OF DECEASED W. J. WILSON		27. SIGNATURE OF WITNESS W. J. WILSON	

BUREAU V. 3

JAN 28 1957

RECEIVED

993

CERTIFICATE OF DEATH

Reg. Dist. No.

01021

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chertsey		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 Greenbelt Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital		d. STREET ADDRESS 125 E. Ridge Road	
3. NAME OF DECEASED (Type or print) First Middle Last William O - walton		4. DATE OF DEATH Jan 27, 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Va
13. FATHER'S NAME Jesse walton		14. MOTHER'S MAIDEN NAME Ann willie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Hospital Records Chertsey, Md	
16. SOCIAL SECURITY NO.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO (c) Senile Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-21, 1957, to 1-27, 1957, that I last saw the deceased alive on 1-27, 1957, and that death occurred at 2:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William Eisner		DATE SIGNED 1-28-57	
PHYSICIAN'S NAME (Type) WILLIAM EISNER		ADDRESS (Street, city or town, state) 30 B Ridge Rd Greenbelt, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/30/57	22c. NAME OF CEMETERY OR CREMATORY Thomas Brook Cemetery	22d. LOCATION (City, town, or county) (State) Thomas Brook, Va.
23. FUNERAL DIRECTOR'S SIGNATURE F Gascho Sons		ADDRESS Lyttleton, Md	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE JAN 30 57			

BUREAU V. S.

JAN 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

994

CERTIFICATE OF DEATH

Reg. Dist. No.

010222
239

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 16.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Laurel		c. LENGTH OF STAY IN 1b 12-27-1955	
d. NAME OF HOSPITAL (If not in hospital, give street address) Laurel Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HELEN CECELIA WEAVER		4. DATE OF DEATH Month 1 Day 7 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-1888
9. AGE (In years lost birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Binding in US Printing office.	11. BIRTHPLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY? N.S.A.		13. FATHER'S NAME WILLIAM SANDSTRUM	
14. MOTHER'S MAIDEN NAME HONORA O'BRIEN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital records, Laurel Sanitarium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Intestinal obstruction and Aspiration pneumonia (b) generalized arteriosclerosis (c) with psychotic reaction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 day several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-7-1956, to 1-7-1957, that I last saw the deceased alive on 1-7-1957, and that death occurred at 8:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE LINDA P. KRAEMER M.D.		ADDRESS (Street, city or town, state) Laurel Sanitarium Laurel Md.	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		LAUREL Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 1/10/57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.W. Lewis Sons Co - Wash DC		24a. REC'D BY REGISTRAR 10 1957	
24b. REGISTRAR'S SIGNATURE Phyllis Brachman			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>James E. Smith</i>		DATE OF DEATH <i>Jan 10 1957</i>	
AGE <i>65</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Retired</i>		MARITAL STATUS <i>Married</i>	
PLACE OF BIRTH <i>St. Louis, Mo.</i>		DATE OF BIRTH <i>Jan 10 1892</i>	
PLACE OF DEATH <i>St. Louis, Mo.</i>		DATE OF DEATH <i>Jan 10 1957</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. E. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>Jan 10 1957</i>		DATE OF SIGNATURE <i>Jan 10 1957</i>	

BUREAU V. 3

JAN 10 1957

RECEIVED

995

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 7 Mos.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY XXXX Balto.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5312 Edmonston Road				d. STREET ADDRESS 230 North Milton Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ellen		First Barbara		Middle WEISS		Last		4. DATE OF DEATH Month Jan.	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 July		9. AGE (In years last birthday) 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME John Ven Douern				14. MOTHER'S MAIDEN NAME May Zimmerman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None		17. INFORMANT Elizabeth Woodyard					
Address Same as # 1 Daughter									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-10-57 , 19 57 , to 9-15-57 , 19 57 , that I last saw the deceased alive on 1-10-57 , 19 57 , and that death occurred at 9:15 P M, from the causes and on the date stated above.									
ACTUAL SIGNATURE J. P. Clum				M.D. H. J. Hall		ADDRESS (Street, city or town, state) Baltimore Md.		DATE SIGNED 1-11-57	
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.			
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC				ADDRESS Baltimore Md.		24a. REC'D BY REGISTRAR James S. Sander		24b. REGISTRAR'S SIGNATURE James S. Sander	
				DATE JAN 14 1957					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		John M. Malon	
Sex		Male	
Race		White	
Date of Birth		1900	
Place of Birth		Maryland	
Date of Death		1957	
Place of Death		Maryland	
Cause of Death		Heart Disease	
Occupation		Farmer	
Signature of Physician		J. M. Malon	

*Dr John Malon contacted
re regards the artifact*

BUREAU V. S.

JAN 14 1957

RECEIVED

996
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PRINCE GEORGES Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Cherami P. Westcott				4. DATE OF DEATH Jan. 25 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-4-26	
9. AGE (In years last birthday) 30 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William White				14. MOTHER'S MAIDEN NAME Laura Fuller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Kenneth Westcott 3829 Thornwood Rd. Landover, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 176X CARCINOMATOSIS DUE TO SQUAMOUS CELL CARCINOMA OF VAGINA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 7 mos DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1 , 19 56 , to JAN 25 , 19 57 , that I last saw the deceased alive on JAN 25 , 19 57 , and that death occurred at 5:40 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donat Comeau M.D.				ADDRESS (Street, city or town, state) 3503 Perry St		DATE SIGNED 1/25/57	
PHYSICIAN'S NAME (Type) Norman Donat Comeau				DATE 1/25/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Jan 29 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE See Funeral Home ADDRESS 300-4 St NE Wash. D.C.				24a. REC'D BY REGISTRAR W. K. Smith		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V.

JAN 29 1957

928

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE WILL</u>		4. DATE OF DEATH Month Day Year <u>JAN. 23 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 10, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>BAVARIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ADAM WILL</u>		14. MOTHER'S MAIDEN NAME <u>DOROTHEA ECKENHOEFER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>Sacred Heart Home Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>10 years.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>7 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September, 1955</u> , to <u>Jan. 23</u> , 1957, that I last saw the deceased alive on <u>Jan 21</u> , 1957, and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>322 H Street, NE</u> DATE SIGNED <u>1-23-57</u>			
ACTUAL SIGNATURE <u>Thomas F Collins</u> M.D.		DATE SIGNED <u>1-23-57</u>	
PHYSICIAN'S NAME (Type) <u>Thomas F. Collins, M.D.</u>		<u>Washington 2, DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-26-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balls Blad. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tracy Funeral Home - Catonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>1-28-1957</u>	24b. REGISTRAR'S SIGNATURE <u>James Leaver</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01026

Reg. Dist. No.

997

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Mitchellville d. STREET ADDRESS Route 2; Box 17 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Nathaniel Eugene Williams		4. DATE OF DEATH Month Day Year January 2, 1957		5. SEX Male			
6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 20, 1956			
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Robert Eugene Williams				
14. MOTHER'S MAIDEN NAME Ruth Estelle Griffith			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT Address Mother; same address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 391.2 DUE TO Suppurative otitis media and bronchopneumonia. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John T. Maloney</i>				DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> January 2, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			
22d. LOCATION (City, town, or county)		(State)		23. FUNERAL DIRECTOR'S SIGNATURE			
23a. ADDRESS		23b. REC'D BY REGISTRAR		23c. REGISTRAR'S SIGNATURE			
23d. DATE		23e. ADDRESS		23f. DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2077191XV4

14 57

BUREAU V. S.

3. Содержание и структура официального

61001

1991-1992 : 10/10

Josephine Williams

1992-1993

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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS c. LENGTH OF STAY IN b 24 Years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PR. GOE'S. CO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS d. STREET ADDRESS 6075- Allentown Road S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER C. WILLIAMS First Middle Last 4. DATE OF DEATH Jan. 11th. 1957 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 29- 1892 9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov. 11. BIRTHPLACE (State or foreign country) Washington, D.C. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Zadoc Williams 14. MOTHER'S MAIDEN NAME Mary G. Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Bessie N. Williams Address 6075- Allentown Road S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial Decompensation 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Insufficiency DUE TO (c) general arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) mild acute Bronchitis for past 5 days		INTERVAL BETWEEN ONSET AND DEATH 3 hours 1 yr unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 8 , 19 57 , to Jan 11 , 19 57 , that I last saw the deceased alive on Jan 11 , 19 57 , and that death occurred at 2:10 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5440- Silver Hill Road S. E. Jan. 11-57 ACTUAL SIGNATURE Paul C. Van Natta M.D. PHYSICIAN'S NAME (Type) Washington 28, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 14- 57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. ADDRESS 1661- Good Hope Rd. S.E. Washington 20, D.C.		24. RECEIVED BY REGISTRAR JAN 14 1957 DATE REGISTRAR'S SIGNATURE Carrie Campbell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 8 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

IAN 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01028

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
c. LENGTH OF STAY IN 1b <u>1 year</u>		d. STREET ADDRESS <u>Route #1 Box 560</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route #1 Box 560</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cornelia Elizabeth Windsor</u>		4. DATE OF DEATH Month Day Year <u>January 9 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 18, 1866</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Mary Walker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Robert Windsor, son</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>January 9, 1957</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>	22d. LOCATION (City, town, or county) (State) <u>Piscataway MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Seminars Bros.</u>		24a. REC'D BY REGISTRAR <u>1661-2nd Paper SE Wash. DC</u>	
ADDRESS <u></u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	
DATE <u>JAN 14 1957</u>			

RECEIVED

JAN 14 1957

BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01029

1039

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Pr. Geo's. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naylor		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naylor	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 84, Naylor, Maryland.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Helen Last Windsor		4. DATE OF DEATH Month Jan. Day 22, Year 1957.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 6, 1956
9. AGE (In years lost birthday) yrs. 1 Months 16 Days 16 Hours Min. 		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilmer J. Windsor		14. MOTHER'S MAIDEN NAME Dorothy Jane Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Wilmer J. Windsor		Address Naylor, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lobular Pneumonia DUE TO (b) Acute upper Respiratory Infection DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X 3 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from Dec 6 , 19 56 , to Jan 22 , 19 57 , that I last saw the deceased alive on Jan 21 , 19 57 , and that death occurred at 3:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE V. M. Seron		ADDRESS (Street, city or town, state) DATE SIGNED Agawam Md 1/22/57	
PHYSICIAN'S NAME (Type) V. M. SERON M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/24/57	22c. NAME OF CEMETERY OR CREMATORY St. Peter's Catholic Cem:	22d. LOCATION (City, town, or county) (State) Waldorf, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR Jan 25 1957	
ADDRESS 		24b. REGISTRAR'S SIGNATURE H. H. Schuch	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

998

CERTIFICATE OF DEATH

01031

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3422-Tilden Street</u>		d. STREET ADDRESS <u>3422-Tilden Street</u>	
3. NAME OF DECEASED (Type or print) <u>MARTHA CHARLOTTE XANDER</u>		4. DATE OF DEATH <u>January</u> <u>10</u> 19 <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u>10</u> Days <u>6</u> Hours <u>8</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>in own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Addison Lewis Smith</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Parsons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Paul I. Neuhaus</u>		Address <u>Wash. D.C. 2643-Myrtle Ave, N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive - arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>nodular goiter</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>40 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>57</u> , to <u>Jan 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>57</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2503 Queens Chapel Rd., Mt. Rainier, Md.</u>			
ACTUAL SIGNATURE <u>Irvin M. Grassgreen</u> M.D.		DATE SIGNED <u>1-1-57</u>	
PHYSICIAN'S NAME (Type) <u>IRVIN M. GRASSGREEN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-4-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md. Pr. Geo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home Inc.</u>		ADDRESS <u>Mt. Rainier, Md.</u>	
24a. REC'D BY REGISTRAR <u>Quelovich</u>		24b. REGISTRAR'S SIGNATURE	



JAN 7 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01032

999

CERTIFICATE OF DEATH

Reg. Dist. No.

745

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hospital</u>		d. STREET ADDRESS <u>4512 Buchanan St</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Ovidio</u> Last <u>Yorkdale</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-90</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anton Prince</u>		14. MOTHER'S MAIDEN NAME <u>Annie Berg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO <u>with metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. f. 1. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 11</u> , 19 <u>53</u> , to <u>Jan 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 11</u> , 19 <u>57</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>1-11-57</u>	
PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>		RIVERDALE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/15/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Leach's Sons</u>		ADDRESS <u>4939 Baltoque Hyattsville, Md</u>	
24a. REC'D BY REGISTRAR <u>James Seacres</u>		24b. REGISTRAR'S SIGNATURE <u>James Seacres</u>	
DATE <u>16 1957</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1912</i>	
5. PLACE OF BIRTH <i>Baltimore, Md</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 1 1935</i>	
9. NAME OF SPOUSE <i>Jane Doe</i>		10. PLACE OF MARRIAGE <i>Baltimore, Md</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. PLACE OF DEATH <i>Home</i>	
13. DATE OF DEATH <i>Jan 16 1957</i>		14. TIME OF DEATH <i>10:00 AM</i>	
15. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		16. SIGNATURE OF REGISTRAR <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>	
39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01033

1000

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Hill</i>		c. LENGTH OF STAY IN 1b <i>12</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>8709 Quebec St.</i>		d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Prince Georges General Hospital</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <i>Berwyn Heights</i>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>William</i> Last <i>Yost</i>		4. DATE OF DEATH Month <i>Jan.</i> Day <i>8</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/31/91</i>
9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cressman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Star Newspaper</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Robert Yost</i>		14. MOTHER'S MAIDEN NAME <i>Lillian M. Connor</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>578-10-2103</i>	
17. INFORMANT <i>Lillian E. Yost</i>		Address <i>Berwyn Heights, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO (c) <i>Cerebral Arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan</i> , 19 <i>57</i> , to <i>Jan</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1-7</i> , 19 <i>57</i> , and that death occurred at <i>1:15</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. C. Etienne</i> M.D.		ADDRESS (Street, city or town, state) <i>College Park, Md</i>	
PHYSICIAN'S NAME (Type) <i>W. C. ETIENNE</i>		DATE SIGNED <i>1-8-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/11/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>East Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. S. S. Sons Hyattsville, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>Jan 4 57</i>		24b. REGISTRAR'S SIGNATURE <i>On Law</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]	
6. OCCUPATION [REDACTED]		7. MARITAL STATUS [REDACTED]		8. EDUCATION [REDACTED]		9. RELIGION [REDACTED]		10. RACE [REDACTED]	
11. CAUSE OF DEATH [REDACTED]		12. MANNER OF DEATH [REDACTED]		13. PLACE OF DEATH [REDACTED]		14. DATE OF DEATH [REDACTED]		15. TIME OF DEATH [REDACTED]	
16. SIGNATURE OF DECEASED [REDACTED]		17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF DECEASED [REDACTED]		19. SIGNATURE OF WITNESS [REDACTED]		20. SIGNATURE OF DECEASED [REDACTED]	
21. SIGNATURE OF DECEASED [REDACTED]		22. SIGNATURE OF WITNESS [REDACTED]		23. SIGNATURE OF DECEASED [REDACTED]		24. SIGNATURE OF WITNESS [REDACTED]		25. SIGNATURE OF DECEASED [REDACTED]	
26. SIGNATURE OF DECEASED [REDACTED]		27. SIGNATURE OF WITNESS [REDACTED]		28. SIGNATURE OF DECEASED [REDACTED]		29. SIGNATURE OF WITNESS [REDACTED]		30. SIGNATURE OF DECEASED [REDACTED]	
31. SIGNATURE OF DECEASED [REDACTED]		32. SIGNATURE OF WITNESS [REDACTED]		33. SIGNATURE OF DECEASED [REDACTED]		34. SIGNATURE OF WITNESS [REDACTED]		35. SIGNATURE OF DECEASED [REDACTED]	
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